COLISEUM MEDICAL CENTERS

FACULTY AND STUDENT CLINICAL AFFILIATION ORIENTATION MANUAL

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Welcome

We are delighted to have you as a part of the healthcare team at CMC. It is our desire to provide you with a meaningful and enjoyable clinical rotation. This manual has been developed to help facilitate your experiences here at CMC in conjunction with your instructor-led orientation on site.

Orientation Instructions & Requirements

Please save a copy of the online manual that you can refer to when needed. You will need to print a copy of the Environment of Care/Hospital Safety Module Quiz Blank Answer Sheet and the HIPAA Quiz Blank Answer Sheet at the end of the manual and complete the post tests. A minimum score of 85% is required to demonstrate your cognitive knowledge prior to your first clinical day. You will also need to print the Confidentiality Security Form, fill in the appropriate information, and give to your instructor with both quiz answer sheets for grading. A physical orientation to your assigned clinical area will be facilitated by your clinical instructor prior to or on the first day of clinical rotation.
General Guidelines, Expectations and Policies

1. When you are in your clinical setting, you are expected to adhere to the facility’s policies and procedures. All policies and procedures may be found online on each unit for easy reference via the Atlas Insight Intranet home page.

2. Every patient is under the direct care of a CMC RN. Students under the supervision of a clinical instructor may contribute to this care according to hospital policies. A consent form for care/treatment to be rendered by supervised students is signed by the patient on admission.

3. Students are expected to wear a school issued ID badge whenever in the hospital.

4. Students will arrive and leave as scheduled. All changes in schedules will be communicated to the clinical nurse managers by the instructor.

5. Abide by the Patient’s Bill of Rights guidelines, including pain assessment, and report any suspected abuse to clinical instructor/unit manager (See Patient’s Bill of Rights).

6. Document status of patient’s Advanced Directives and insure a copy of the document is in the patient’s chart (See Advanced Directives).

7. Utilize ethical considerations in problem solving ethical dilemmas and report all ethical issues to clinical instructor/unit manager (See Ethics & Compliance).

8. Complete routine assigned patient care with considerations of age, spiritual, special needs, culture and values keeping the assigned CMC RN aware of patient care progress and any patient related problems as they occur (See Age-Related Risk Hazards).

9. Give a detailed, current report on your assigned patient(s) to the appropriate nurse responsible for the patient BEFORE LEAVING THE UNIT.

11. Ensure patient safety and welfare while providing patient care by adhering to all Environment of Care guidelines and related policies/procedures:

   a. Report chemical hazards/spills and handle hazardous chemicals in accordance with the MSDS’s (Material Safety Data Sheets) maintained in every work area (See Material Safety Data Sheets).
   b. Report malfunctioning equipment as required per the Safe Medical Device Act.
   c. Recognize and be able to report hospital “Codes” (See Emergency Codes).
   d. Observe radiation precautions.
   e. Practice safe ergonomic work habits to prevent injury.

12. Identify self appropriately when answering the phone; do not accept phone/verbal orders from physicians or other providers.

13. Park only in designated parking areas as instructed by your clinical instructor. Students should park in the Centreplex Parking lot on the outside of the hospital fence where hospital employees park. Students should not park in the areas near the buildings. These spaces are for patients and visitors.

14. Only smoke in designated areas outside the hospital (See Smoking Policy).

15. Maintain patient confidentiality according to HIPAA standards (See Confidentiality).

16. Adhere to infection control policies and Standard Precautions policies (See Infection Control).

17. Students and Faculty are NOT eligible for any discounts that hospital employees receive in the cafeteria.
MISSION STATEMENT
COLISEUM MEDICAL CENTERS

Above all else, we are committed to the care and improvement of human life. In recognition of this commitment, we strive to deliver high quality, cost effective healthcare in the communities we serve.

In pursuit of our mission, we believe the following value statements are essential and timeless.

- We recognize and affirm the unique and intrinsic worth of each individual.
- We Treat All Those We Serve with Compassion and Kindness
- We act with absolute honesty, integrity and fairness in the way we conduct our business and the way we live our lives.
- We trust our colleagues as valuable members of our healthcare team and pledge to treat one another with loyalty, respect and dignity.

VISION STATEMENT
COLISEUM MEDICAL CENTERS

Our vision is to become a hospital-physician integrated provider of inpatient and outpatient healthcare services. Integrated medical services shall be developed through a variety of vehicles including, but not limited to, traditional inpatient acute care, outpatient medical services, ambulatory care services, primary care services and cooperative relationships with our physicians. We further envision development of specific programs and services related to healthcare, to better serve our patients and physicians. Finally, we desire to be the hospital of choice for patients, physicians, and employees.
IDENTIFICATION OF PATIENT

All patients admitted to Coliseum Medical Centers, Day Hospital Center and the Emergency Department will have a hospital issued identification band.

ARMBAND INFORMATION
Armbands will include the patient’s full name, billing number, date of birth, location (room #) and medical record number. Patients must use the same name from pre-op, through registration and hospital stay.

Aliases: Patients may not use an alias or modified version of their name. This is to assure that the patient’s medical record is consistent and information can be retrieved from a single medical record. Patient’s who are concerned about their identity should be encouraged to request “No Press – No Info”.

ESTABLISHING PATIENT IDENTITY

Registration: During the process of registration, the patient’s identity will be confirmed by picture identification when possible. In the following situations, a picture identification may not be available.

Infants/Children: Parent, guardian or custodian must provide identification for themselves. This identification is copied and used if the infant/child’s identity is questioned during the hospital stay.

Unconscious individual / Emergency Department: Patient will be registered using the “short form”. The patient will be registered as “Jane Doe” or “John Doe”. In the event there is more than one unidentified individual, numbers will be attached to their name (“Jane Doe #2”). When their identity becomes known, a new armband will be issued with their actual name. None of the other identification information on the armband should change. Both armbands will be left on the patient. If it is later discovered that the patient has had previous encounters, medical records should be notified to merge the records after discharge into one medical record number.

Emergency Department: If the patient is sent for their medical screening prior to receiving an identification band, then all information should be documented on the short form. The short form is given to the registration clerk who will confirm the patient’s identity by picture ID if possible. When a patient from the Emergency Department is admitted, the emergency identification band is to remain on the patient in addition to the inpatient band.

Pre-Admission Testing: All pre-op testing and diagnostics should be placed by confirming the patient’s name and account number. When the patient presents for their procedure, they should be asked to state their name and birth date. If correct, they should be shown their face sheet with demographics to review and confirm.

Day Hospital: When a patient arrives at Day Hospital, all admission paperwork and pre-op testing information should be organized into a chart and confirmed by name and birth date. The patient
must be asked to state their name, date of birth and surgeon. This is compared to the pre-printed armband and if correct, the armband is placed on the patient.

**Armbands for Newborns:** Armbands for newborns will be placed per Nursing Policy. Newborn infants will have an identification band placed on both the ankle and wrist. Mothers will have both their own and their infant identification band placed on their wrist. In instances where newborns cannot be banded due to prematurity, the armband should be placed on the radiant warmer or isolette. In addition, a picture should be taken and attached to the warmer/isolette. Once infants develop and are removed from the isolette or warmer, they should have an armband placed on their wrist or ankle. This should be done by a nurse that is familiar with their care. Infants should not leave the NICU without an armband on OR must be transported in a warmer/isolette labeled with their name and account number, by a nurse familiar with them and responsible only for them during the time out of the NICU.

**Neonatal Transport:** When the decision is made for transport, the infant to be picked up will be assigned a “downtime” hospital number beginning with “99999”. A blank armband with this number written on it will also be created. When the transport team arrives at the delivering hospital, a member of the team will attach the armband to the infant in addition to the originating hospital’s armband. This should be done before any treatment is rendered. If it is not possible to attach an armband due to prematurity, the armband should be attached to the transport device. This should be done before any treatment is rendered. When the transport team arrives at the hospital, the temporary armband should be replaced by the actual armband in the same manner. The originating hospital’s armband should remain on the infant if possible. If the armband must be removed, it should be secured in the patient’s medical record to use in the discharge to the parent.

**APPLICATION OF ARMBAND**

Armbands will be placed on the patient as part of the registration process. Identification bands should be placed on the wrist when possible except for special circumstances listed below. Identification bands may be placed on the ankle of small children or infants. Identification bands must remain on the patient until discharge.
PATIENT IDENTIFICATION IN DATA ENTRY
When possible, the patient’s account number should be used to access the patient’s medical record, NOT THE PATIENT’S NAME. The account number is unique for each admission. This ensures that all information is attached to the correct admission. It also decreases the chances of wrong information being included on the same or similarly named patients’ records.

VERIFICATION OF PATIENT IDENTITY USING THE IDENTIFICATION BAND

Patients with Armbands: They should have an armband placed on their wrist or ankle by a nurse familiar with their care. Infants should not leave the NICU without an armband on OR must be transported in a warmer/isolette labeled with their name and account number, by a nurse familiar with them and responsible only for them during the time out of the NICU.

Emergency Department
If the patient is sent for their medical screening prior to receiving an identification band, then all information should be documented on the short form.
The short form is given to the registration clerk who will confirm the patient’s identity by picture ID if possible.
When a patient from the Emergency Department is admitted, the emergency identification band is to remain on the patient in addition to the inpatient band.

Neonatal Transport
The originating hospital’s armband should remain on the infant if possible. If the armband must be removed, it should be secured in the patient’s medical record to use in the discharge to the parent.
Confirm exact patient name compared to the requisition and patient armband
Confirm exact patient account number or medical record number as compared to the requisition and patient armband.

Both steps must be confirmed for patient identification to be verified.
When possible, confirm by asking the patient their name as a question such as “Good morning, I am from the lab, can you verify your name for me?” If the patient cannot respond because they are a child or clinically incapacitated, a friend or family member may be asked.

Name Alert
A “Name Alert” will be issued when two patients with the same or similar names are on the same unit. All patients will be identified using the patient armband.
During shift report, nurses will identify the presence of patients with same names.
The patient’s chart, MAR, and cardex will be marked with the statement “Name Alert”.
A notice will be posted at the nurses’ station denoting the patients with the same name.

Jane/John Doe
Since the patient’s name is not known, verification should be done by matching both the medical record number and the patient account number.
Blood Bank
Additional armbands are used for patients who have had blood drawn for blood or blood products. The procedure for patient verification and identification are outlined in the Policy “Blood Administration”.

Outpatient Clinical Patients (non-surgery/observation)
Individuals coming for outpatient clinical testing such as radiology or laboratory do not have identification armbands. The identity of outpatient clinical patients must be verified by asked the patient to state his name and date of birth. This should be compared to the requisition for confirmation.

REMOVAL AND REPLACEMENT OF AN ARMBAND
It may be necessary to remove a patient identification armband because of interference with a medical test, treatment or procedure.

Only someone, who was in the physical presence of the patient when the armband is removed, may replace the armband without repeating the verification process. Examples would be 1) A nurse removes an armband to begin an IV. She may then make a new armband and place it back on the patient. 2) The armband is removed by anesthesia pre-op, the nurse present at bedside when the armband was removed may place a new armband on the patient.

If a patient is found without an armband, the verification process must be repeated by asking the patient or present family member to state the patient’s name and birth date.
ASSESSMENT and REASSESSMENT OF THE PATIENT

The goal of the patient assessment is to determine what kind of care is required to meet the needs of the patient initially as well as their needs as they change in response to care. In order to provide the patient with the right care at the time it is needed, qualified individuals in the hospital assess each patient's care needs beginning with the admitting process and continuing through the discharge.

Those disciplines providing patient assessment and reassessment at Coliseum Medical Centers possess specialized knowledge and consider the relevant patient history, biophysical, psychosocial, behavioral, spiritual, environmental, educational, self-care and discharge planning needs of the patient. Judgment and skill derived from medical sciences is used in planning for the patients assessed needs. Under the auspices of Coliseum Medical Centers, health care professionals from varying disciplines function collaboratively as part of an interdisciplinary team to plan patient care based on an analysis of the findings from the assessment process in order to achieve positive patient outcomes.

I. Pre-Admission Assessments and Assessments

A. Who may perform assessments

Patient assessment and reassessment are performed by the following disciplines:

Physicians    Pharmacists
Registered nurses    RN Case Managers
Registered dietitians    Speech therapists
Respiratory therapists    Occupational therapists
Physical therapists    Recreational therapists

The data gathered, the scope of assessment and reassessment, the analysis of data, and the framework for decision making based on that analysis is described in department specific policies and procedures.

B. Who may collect Data

Additionally, appropriate data can be collected by these individuals to aide in the assessment process:

Registration Clerk    Licensed Practical Nurse
Nursing Assistant    Unit Secretary
Technician    Dietetic Assistant
FANS Supervisor    Monitor Tech
C. Initial Assessment

During the initial assessment the staff members need to find out the reason why the patient was admitted. They must take into account the patient’s immediate and emerging needs and consider not only the physiological status but also the psychological and social concerns. During this initial assessment the staff determines what care the patient needs as well as any further assessments required.

The process begins with collecting data about each patient’s physical and psychosocial status and health history. Because the patient’s cultural and family/significant other contexts and individual background are important factors in his or her response to illness and treatment, it is important to include them in the assessment process. The data are analyzed in order to produce information about each patient’s care needs, and to identify additional information required. Care decisions are based on information developed about each patient’s needs.

The type of data collected, assessed, and analyzed are:

- Demographic
- Allergies
- Developmental stage
- Religion
- Ability to communicate
- Physical findings
- Signs of Abuse/Neglect
- Psychosocial
- History of drug and alcohol use and treatment
- Physical, to include pain
- Environmental
- Discharge Planning
- Self Care
- Education
- Functional Status
- Nutritional Status
- Functional Assessment
- Spiritual
- Cultural
- Alcohol and Substance Abuse
- Patient’s cultural and Family/significant other
- Financial Resources
- Diagnostic testing (Laboratory, radiologic, electrodiagnostic, function test, imaging)
- DVT Screening
- Skin assessment
- MRSA screening
At Coliseum Medical Centers, we recognize that there may be special needs for dying patients. For this population, an assessment is made of the social, spiritual, and cultural variables that influence the perceptions and expressions of grief by the individual, family members, or significant others.

The information gathered at the first patient contact may indicate that the patient needs further assessment. This will depend on the patient’s diagnosis, the care he or she is seeking, the care setting, and the patient’s response to any previous care, his or her consent to treatment, and the anticipated length of stay.

During the initial assessment the Registered Nurse ask screening questions for other disciplines in order to determine if further assessment is needed. Those screening questions that would lead to further assessment by those disciplines were developed by each department and deemed appropriate and approved by an interdisciplinary documentation team. These specialties may include, but are not limited to Nutrition, Rehabilitation, Speech Therapy, Case Management, and Physical Therapy.

Pain is assessed in all patients. In the initial assessment, those patients experiencing pain are identified. A more comprehensive assessment is performed when warranted by the patient’s condition (See Pain Management Policy).

A qualified member of the medical staff with appropriate clinical privileges completes the Medical History and Physical within 24 hours of admission.

Data analyzed may include:

- Need for further assessment by other disciplines
- Admission Assessment data assess by the Registered Nurse
- History and Physical
- Diagnostic Test Results ordered by the Physician
- Consults

The initial assessment is performed and documented by the Registered Nurse. The time frame for completion depends on the type of patient, the complexity and duration of care, and the dynamics of conditions surrounding their care. See chart for Assessment/Reassessment time frames. The Interdisciplinary Plan for Patient Care is initiated after careful consideration is given to all information from all sources.

D. Reassessment

Interdisciplinary team members work in a collaborative manner to integrate assessment/reassessment information into a comprehensive plan of care for the patient. Reassessment is the key to determining if care decisions are appropriate and effective. Patients are reassessed throughout the care process at regular intervals.
In addition to the specified time intervals for reassessment, the patient will be reevaluated to determine response to specific treatment, or when a significant change occurs in the patient's condition or diagnosis. Reassessment shall occur at least as follows:

- During and following any invasive procedure
- Following a change in the patient's condition or level of care
- During and following the administration of blood and blood products
- Following any adverse drug reaction or allergic reaction
- During and following any use of physical restraints

See chart for Assessment/Reassessment time frames.

E. Discharge Planning

Discharge planning is initiated on admission and is incorporated in the admission assessment. Potential discharge related needs of the patient and family, caregiver or significant other are identified on admission in order to provide for continuity of care and appropriate and timely post discharge care.

F. Abuse/Neglect

Knowing that patients who have a history of abuse or neglect may be unable or reluctant to speak about it, makes it of paramount importance for the hospital staff to identify if a patient may have been abused and the extent and circumstances of the abuse in order to give the appropriate care. (See Abuse and Neglect policy).

All patients are screened for abuse and neglect throughout the hospital. During the initial assessment the Registered Nurse asks questions to screen for abuse/neglect. Additionally, the physician may note information related to this. Other employees may interact with the patient and share the responsibility to report any thing they may note that might help identify a possible victim.

G. Alcohol or Drug Dependencies

The patient's history of alcohol, nicotine, and other drug use, including age of onset, duration, intensity, patterns of use, and consequences of uses are included in the assessment.

H. Pediatrics/Infants/Children and Adolescents

assessment process for an infant, child or adolescent patient is individualized appropriately to age and needs. The initial patient care assessment completed by a RN of infants, children, and adolescents will include, as appropriate, the following items that will be documented in the patient's medical record:
1. Nutritional Status - Pediatric

All children under the age of 12 years will be weighed and if there is a 10% change from the patient’s usual body weight, the dietician is notified per the automated system in Meditech for follow-up.

2. Head Circumference

All children under the age of 18 months will have head circumference measured in centimeters and documented in the medical record.


All children will receive an assessment of their emotional, cognitive, communication, educational and social needs.

4. Immunization Status

All children will receive an assessment of their current immunization status. Documentation will occur in the medical record.

5. Family/Guardian

The effect of the family or guardian on the patient’s condition and the effect of the patient’s condition on the family or guardian will be assessed. In addition, the family or guardian’s expectations for and involvement in the patient’s assessment, initial treatment and continuing care will be assessed and documented.

II. Department-Specific Assessment/Reassessment

A. Nursing Services

A registered nurse collects appropriate and sufficient information from the patient and/or significant others in order to assess the patient’s need for nursing care in all settings where nursing care is provided. The scope of assessment includes but is not limited to, arrival information, reason for visit, history, allergies, current medications, immunizations as appropriate to age, physical exam (including vital signs and other body measurements as appropriate to age and diagnosis), psychosocial, religious, spiritual, cultural and financial data which could affect care, functional status that includes mobility and ability to carry out activities of daily living, pain, history of alcohol and drug use and treatment, educational readiness to learn, learning preferences, educational level, and discharge planning needs.
The RN reviews the patient’s health history at the time of admission to ensure that all information given is accurate and complete. The nurse is responsible for correcting any incorrect data that has been recorded on the health history, and for updating the health history during the hospitalization.

1. Registered Nurses may complete the following:
   - The full initial patient care assessment
   - Must confirm any information collected by other nursing staff members
   - May orient the patient and family/significant others to the unit, room, patient rights and responsibilities
   - May complete patient identification and collection of valuables and medications for proper handling
   - Must identify patient problems or needs from the assessment information and will initiate and individualize a plan for care

2. Licensed Practical Nurses may complete the following:
   - May complete the data collection portion of the initial patient care assessment and forward to the Registered Nurse for validation
   - May orient the patient and family/significant others to the unit, room, patient rights and responsibilities
   - May complete patient identification and collection of valuables and medications for proper handling.

3. Nursing Assistant/Technicians/Nurse Extern may complete the following:
   - May orient the patient and family/significant others to the unit, room, patient rights and responsibilities
   - May complete patient identification and collection of valuables for proper handling
   - May obtain vital signs, height and weight

B. Medical/Surgical and Post Partum/GYN Nursing Units

1. Assessment

   The RN begins an initial assessment of the patient’s needs on admission to the unit. The assessment is completed within 12 hours.

2. Reassessment

   Information is collected on an ongoing basis to reflect the patient’s current status and care needs. Each patient is reassessed at a minimum of every shift by a
RN or LPN and with any significant change in the patient’s condition. Ongoing reassessments occur additionally whenever needed in response to medication, pain, treatment etc. An RN reassesses the patient at least every 24 hours. Documentation of reassessments will be found in the nursing notes in the patient’s medical record.

The RN upon the patient’s arrival to the unit initially completes the postoperative assessment. The LPN may then complete the reassessments as needed/ordered. Documentation of all reassessments will be found in the nursing notes, postoperative assessment or shift assessment in the patient’s medical record.

C. Critical Care Units

1. Assessment

The RN begins an initial assessment within 5-10 minutes of arrival on admission to the unit. The assessment is completed within 4 hours.

2. Reassessment

Information is collected on an ongoing basis to reflect the patient’s current status and care needs. Each patient is reassessed every 4 hours and with any change in condition by a RN. Because of the complex nature of the patient’s condition, reassessment will happen more frequently. Ongoing reassessments occur additionally whenever needed in response to medication, pain, treatment etc. An RN reassesses the patient at least every 4 hours. Documentation of reassessments will be found in Meditech on the Nursing Intervention Screen.

D. Cardiovascular Step Down Unit

1. Assessment

The RN begins an initial assessment of the patient’s needs within 1 hour on admission to the unit. The assessment is completed within 6 hours.

2. Reassessment

Information is collected on an ongoing basis to reflect the patient’s current status and care needs. Each patient is reassessed at a minimum of every shift by a RN or LPN and with any significant change in the patient’s condition. Ongoing reassessments occur additionally whenever needed in response to medication, pain, treatment etc. An RN reassesses the patient at least every 24 hours. Documentation of reassessments will be found in Meditech on the Nursing Intervention Screen.
Upon the patient's arrival to the unit from any other in-patient area of the hospital including surgery, the RN completes a re-assessment. The LPN may then complete the reassessments as needed/ordered. Documentation of reassessments will be found in Meditech on the Nursing Intervention Screen.

E. Emergency Department

All patients presenting to the emergency room are assessed rapidly to determine the severity of the presenting chief complaint. Acuity is assigned to each patient during the initial assessment. The acuity determines the time to treatment goals and the amount of time the patient can safely wait to be seen by a primary nurse and physician when no beds or caregivers are immediately available. A comprehensive assessment will be performed on each patient that presents to the emergency department. This assessment may be performed in “triage” or at the bedside. Any patient awaiting a medical screening exam (MSE), regardless of location, will be reassessed at a minimum of hourly and more frequently based upon the acuity assigned. Once the medical screening exam is begun reassessment of the patient will be based upon acuity and/or further orders or changes in the patient’s medical condition.

1. Assessment

The dynamic process of sorting, prioritizing, and assessing the patient. The triage assessment is performed by a qualified RN at the time of presentation and before registration. Triage consists of information, which is obtained, that would enable the Triage RN to determine the acuity. A triage assessment is composed of airway, breathing, circulation and disability, general appearance, eliciting symptom driven presenting complaint(s), and any pertinent objective and subjective data/assessment from the patient or parent or caregiver. A secondary assessment may require, based on acuity, a head to toe survey or a focused physical assessment.

Triage Acuity Category/Priority Category— Categorizes Emergency Department (ED) patients by both acuity and expected resource needs. Acuity is determined by Triage criteria which is stability of vital functions and potential for life, limb or organ threat, the risk for short-term complications, and the amount of patient or family suffering. The triage nurse assigns acuity based on previous experience, training and demonstrated competence. Nursing personnel utilize Triage Criteria to determine the patient’s level of care needs. Our facility uses the Emergency Severity Index (ESI) Acuity System to assign acuity to our patients.

2. Reassessment

- A process of periodic re-evaluation of the patient’s condition and symptoms based on the patient’s acuity determination prior to the initiation of the medical screening exam. May include some or all of the following: vital signs, a focused physical assessment, pain assessment, general appearance, and/or responses to interventions and treatments. Patients
waiting for the initiation of the medical screening exam (MSE) shall have a reassessment performed at a minimum of:

**One (1) hourly or more frequently if condition and acuity warrant.**

- Reassessments after initiation of the medical screening exam (MSE) are performed by RNs according to acuity:
  1. Level (1)/Resuscitative will be performed continuously and documented per code/trauma hospital policies and procedures
  2. Level (2)/Emergent will be documented at a minimum of hourly and more frequently if condition warrants and/or prior to disposition.
  3. Level (3)/Urgent will be performed and documented every 2-4 hours as condition dictates and/or prior to disposition.
  4. Level (4)/Semi-Urgent will be performed prior to disposition or every 4 hours as condition dictates.
  5. Level (5)/Non-Urgent will be performed prior to disposition and more frequently if condition warrants.

**F. Labor and Delivery**

1. **Assessment**

   The Registered Nurse is responsible for the assessment of the patient. Initial assessment begins on arrival to the Labor & Delivery unit and is completed within 2 hours. Certain aspects of this assessment may be delegated to the OB technician (i.e., vital signs, weight, etc.). Information is confirmed and communicated to the attending physician and coordinated for medical and nursing plan of care.

2. **Reassessment**

   Reassessment of patient in labor is ongoing by continuous fetal monitoring and surveillance. The Registered Nurse per physician’s specific order assesses dilatation progress. Vital signs are assessed as per plan of care for the individual patient and their status. Reassessment of the patient that is housed in Labor & Delivery for reasons other than childbirth is made in accordance with guidelines for plan of care for that type patient (i.e., preterm labor, Magnesium Sulfate infusion, or pre-eclamptic patient).
G. Nursery

1. **Assessment**

   The RN begins an initial assessment of the infant’s needs on admission to the unit. The assessment is completed within 8 hours.

2. **Reassessment**

   Information is collected on an ongoing basis to reflect the infant’s current status and care needs. Each infant is reassessed at a minimum of every shift by a RN or LPN and with any significant change in the patient’s condition. Ongoing reassessments occur additionally whenever needed in response to medication, pain, treatment etc. An RN reassesses the infant at least every 24 hours. Documentation of reassessments will be found in the nursing notes in the patient’s medical record.

   Temperature stabilization is very important therefore monitoring occurs every hour until stabilization has occurred and then is continued every four hours during the first twenty-four hours of care. Continued monitoring of the temperature is maintained at least every eight hours.

H. **Neonatal Intensive Care**

1. **Assessment**

   The RN begins an initial assessment of the infant’s needs within 5-10 minutes of arrival to the unit. The assessment is completed within 4 hours.

2. **Reassessment**

   Information is collected on an ongoing basis to reflect the infant’s current status and care needs. Each infant in the intensive care unit is reassessed at a minimum of every two hours by a RN or LPN and with any significant change in the patient’s condition. Infants located in the step down unit are reassessed at a minimum of every four hours and with any significant change in the infant’s condition. Ongoing reassessments occur additionally whenever needed in response to medication, pain, treatment etc. An RN reassesses the infant at least every 24 hours. Documentation of reassessments will be found in the nursing notes in the patient’s medical record.

   Temperature stabilization is very important therefore monitoring occurs every hour until stabilization has occurred and then is continued every four hours during the first twenty-four hours of care. Continued monitoring of the temperature is maintained at least every eight hours.
I. Day Hospital

1. Initial Assessment:

The initial assessment is obtained on admission to Day Hospital by the R.N.

2. Reassessment:

Patients are reassessed every 2 hours while in Day Hospital. The assessment includes diet status, IV, level of consciousness, respiratory status after pre-op, verbal update, safety precautions (call light in reach) and pain assessment to include location, duration and intensity. Vital signs are obtained on admission and every 4 hours.

3. Post-Procedure:

Assess upon arrival to unit including items stated above as well as procedure sites and pain management. Assessments completed at intervals as stated in DHC policy.

J. Operating Room

1. Assessment

During the time a patient is in the Holding Area, the RN completes a preoperative assessment. This assessment includes physical assessment of mental status, limitations, presence of prosthetic devices, evaluation of operative site, skin condition (warmth, moisture, nail beds, rashes, lesions, etc.), known infectious diseases, NPO status, and allergies. The procedure/location is verified verbally and with the consent form. Valuable information can be obtained from the H&P on the chart and lab, EKG, or x-ray reports. The RN verifies that medications have been given and documented, vital signs charted, and the presence of any lines documented (i.e. IV, drains, foley catheter). The circulating RN in the operating room will verify allergies and two people of the OR team will confirm the operative site. Assessments of skin and tissue integrity are performed prior to the application/use of any equipment in the operating room, such as tourniquets, electrocautery pads, or warming units. Anesthesia personnel perform an assessment on patients related to their anesthesia care.
2. **Reassessment**

Anesthesia personnel continuously monitor the patient in the operating room and during transport to the PACU. The RN reassesses the skin and tissue integrity for the effect of any equipment, i.e. tourniquet site and extremity, electrocautery pad site, or area warmed by the warming unit. Pressure points and bony prominences are also assessed.

K. **Endoscopy**

1. **Assessment**

The Endoscopy nurse (RN) will complete an admission assessment on all Endoscopy outpatients. The nursing history may be obtained prior to the procedure via phone. The actual assessment is completed on admission. Inpatients have already been assessed on the nursing unit.

2. **Reassessment**

During the procedure phase the RN obtains an initial set of Vital Signs and evaluates the patient's emotional status. If a cautery is to be used, the condition of the skin at the pad site is documented. Inpatients receive an initial Aldrete scoring assessment. The patency of the IV is monitored. The RN monitors the patient continuously during the procedure, including Vital Signs, LOC, Comfort/Response, and ECG. At the completion of the procedure and prior to transfer the RN reassesses the patient regarding the pad site skin condition, Aldrete scoring, skin (warmth, moisture, jaundice), abdomen (softness, roundness, tenderness, distension) and how the patient tolerated the procedure.

The post procedure recovery nurse assesses the patient’s vital signs and completes the Aldrete scoring upon arrival. The patient is monitored as stated in the hospital’s sedation policy. Prior to discharge the RN reassess the level of consciousness, p.o. status, pain (location, duration, intensity), skin (warmth, moisture, and jaundice), and abdomen (softness, roundness, tenderness, and distension). The IV site is monitored for patency, and when the catheter is removed, whether the catheter is intact and the total amount of fluids infused is documented.

L. **Recovery (PACU)**

1. **Assessment**

A RN immediately upon arrival to the PACU completes the initial admission assessment of the patient’s condition and needs.

2. **Reassessment**
Information is collected on an ongoing basis to reflect the patient’s current status and care needs. Each patient is reassessed by guidelines and policy specific to the PACU, patient’s surgical procedure and changing needs. In the instance of critical events the reassessment will occur more frequently. A complete discharge assessment is completed prior to transfer to another level of care.

M. Case Management

1. Assessment

The initial discharge planning screen is completed as part of the nursing admission assessment. As per the Hospital UR Plan, admission reviews are to be performed within 3 days. This review shall include the appropriateness and clinical necessity of admission, continued stay, supportive services, services required post-discharge and outpatient observation status.

2. Reassessment

Continued stay reviews are performed on a schedule corresponding to the patient’s changing medical status. Reviews will be performed at a minimum of at least twice weekly with the exception of newborns. Newborns that are “thriving and growing” may be reviewed weekly in the absence of dynamic, acute clinical changes.

N. Admission Center

1. Assessment

The Admission Center triages admissions for appropriate level of care. This helps to start the patient in the right status and to determine the severity of illness and intensity of care requirements. The Admission Center RN obtains initial clinical information to assist in this process. This includes the identification of specialty services or equipment such as oxygen, isolation room, telemetry, specialty bed or dialysis. When possible, a basic plan of care is established. Patients are assessed for issues that may affect discharge planning.

2. Reassessment – Not Applicable
O. Laboratory

1. Assessment

A phlebotomist or medical technologist/technician collects appropriate and sufficient information from the patient and/or significant others in order to assess the patient’s needs prior to performing the phlebotomy procedure. The scope of assessment includes but is not limited to, patient’s name, tests ordered, condition of patient’s veins, exclusion of certain sites, physical limitations of the patient, and allergies.

2. Reassessment

Reassessments are done prior to each collection.

P. Imaging

1. Assessment

An initial visual assessment of the patients will be done upon arrival to Radiology. The radiology technologist will check the patient’s demographics and orders. An assessment of the patient’s allergies, medications and lab values will be reviewed and correlated with the radiology procedure. Physical abilities, age-specific criteria and emotional or cognitive condition will be considered with all patients. Explanation and education of ordered procedures will be provided for each patient and/or family member.

2. Reassessment

Information will be collected on an ongoing basis to reflect the patient’s current status and care needs while in Imaging. Reassessments will occur whenever needed in response to procedural techniques specific to imaging procedures.

Q. Nutrition Services

1. Assessment

Dietitians collaborate with Nursing to develop criteria that will identify patients at risk for nutritional problems. Nursing will complete the initial patient screening for nutritional risk during the initial patient assessment. This initial patient assessment includes a series of nutrition related questions. A point value is assigned for each nutrition risk factor. This information is used for the Registered Dietitian (RD) to determine the patient’s risk level. The Positive Nutrition Risk
Report prints automatically daily. Unit-specific pre-established criteria have been reviewed with nursing staff, and are included in the nursing assessment form. A qualified Registered/Licensed (RD/LD) Dietitian will perform the initial nutritional assessment according to risk level (low, moderate or high) (See attached Levels of Care).

2. **Reassessment**

Reassessment will occur according to risk level (See: Levels of Care) and when there are significant changes in patient condition or patient needs. The dietitian (RD/LD) will be made aware of these changes by rounds, visits to the patient care areas, and communication with other members of the health care team or by computer. Information will be collected on an ongoing basis to reflect the patient’s current level of care.

**R. Respiratory Therapy/Cardiopulmonary Therapists**

1. **Assessment**

Upon receiving a request for respiratory services, a Respiratory Care Practitioner will perform and document an assessment as outlined on the Pulmonary Assessment Record. The initial assessment will be completed within 2 hours on the Med / Surg and Rehab floors. Admission to ICU/CVICU/NICU with artificial airway, ventilator dependency, unstable airway, an assessment will be performed stat otherwise within (30) thirty minutes. The Respiratory Care Practitioner will collaborate with the appropriate nursing staff and notify the physician when indicated. Pre-op assessment of the open heart patient will be completed within two hours of notification. The Respiratory Care Practitioner will contact the surgeon if the assessment meets criteria listed in the Society of Thoracic Surgeons (STS) national data base for pulmonary consultation.

2. **Reassessment**

Upon receiving notification of a change in a patient's status, or recognizing such during a patient encounter, the Respiratory Care Practitioner will perform and document a reassessment. NICU ventilator patients are reassessed Q2 hours. ICU ventilator patients are reassessed Q3 hours. CVICU status ventilator patients will be reassessed Q2 hours. During Adult/Neonatal transport, patients are reassessed q 15 minutes until arrival at the receiving facility.

**S. Pharmacy**

1. **Assessment**

A Pharmacist shall assess the patient concerning drug therapy while entering orders on to the patient’s profile before dispensing medications. The pharmacist
will assess the appropriateness of each medication ordered based on patient data available. Inappropriate therapy should be reviewed and the physician consulted if necessary. Changes in the physician’s order should be documented on the patient’s chart. Pharmacists’ interventions should be documented.

Assessment of the patient should include the patient’s age, weight, height, diagnosis, renal function, allergies, current drug therapy, and any other comments and conditions noted.

2. Reassessment

The patient is to be reassessed for appropriate drug therapy with each subsequent medication order.

T. Cardiac Catheterization Lab/EP

1. Assessment

A RN on arrival to the Cath Lab/EP completes a Pre-procedure assessment. This includes all required elements (allergies, pain, vital signs, and past medical history etc.) and is documented in the patients record. From the assessment the Cath Lab nursing plan of care is developed to meet the individualized needs of each patient.

Intra-procedure a RN remains with the patient. The patient is continuously monitored and assessed by the RN using a cardiac monitor, O2 Sat monitor, and a non-invasive BP machine. All diagnostic information is documented in the patients record.

Post procedure a RN assesses the patient for LOC, insertion site, cardiac rhythm, O2 Saturation, blood pressure, and pain control.

2. Reassessment

Reassessments are continuous throughout the procedure and include assessments for adequate pain control and appropriate sedation. Reassessment during the recovery phase is performed by the RN at a minimum of every 10 minutes until discharged from the area.

Reassessments are documented in the patient’s record.
U. Cardiac Catheterization/EP/Special Procedures/Cardiac Catheterization Recovery Unit/TEE

1. **Assessment**

   The RN begins on initial assessment of the patient’s needs or admission to the unit. The assessment is completed prior to procedure.

2. **Reassessment**

   a. **Clear Catheterization**

      Patient who returns from the catheterization lab initially is assessed by the RN upon arrival to the unit. Reassessment of vital signs and groin occurs as per physician orders. Ex. q 15 x 2 or 4, q 20 x 2 or 4 and q 1 x 2 or 4.

   b. **PTCA or Stents**

      Reassessment occurs every 15 minutes x 4, every 30 minutes x 6 and every hour until sheath is removed. Documentation of reassessments will be found in the nursing notes and/or Cardiovascular Unit flow sheet in the patient’s medical record.

   c. **Post Sheath Removal**

      Post Sheath removal reassessment occurs every 15 minutes x 4, every 30 minutes x 6 and every hour until hemostasis is achieved. Documentation of reassessments will be found in the nursing notes and/or Cardiovascular Unit flow sheet in the patient’s medical record.

   d. **TEE**

      Reassessment occurs every 15 minutes X4, every 30 minutes x6 and every hour thereafter in which the patient remains in TEE. Documentation of reassessments will be found in the additional nursing notes and/or the TEE procedure sheet in the patient’s medical record.

V. **Specials Procedures Lab**

1. **Assessment**

   A RN on arrival to the Specials Lab completes a Pre-procedure assessment. This includes all required elements (allergies, pain, vital signs, and past medical history etc.) and is documented in the patient’s record. From the assessment the
Special's Lab nursing plan of care is developed to meet the individualized needs of each patient.

Intra-procedure a RN remains with the patient. The patient is continuously monitored and assessed by the RN using a cardiac monitor, O2 Sat monitor, and a non-invasive BP machine. All diagnostic information is documented in the patient’s record.

Post procedure a RN assesses the patient for LOC, insertion site, cardiac rhythm, O2 Saturation, blood pressure, and pain control.

2. Reassessment

Reassessments are continuous throughout the procedure and include assessments for adequate pain control and appropriate sedation. Reassessment during the recovery phase is performed by the RN at a minimum of every 10 minutes until discharged from the area.

Reassessments are documented in the patient’s record.

W. Rehabilitation Unit (Inpatient)

1. Assessment

All patients referred to the inpatient Rehabilitation Unit will be assessed by a Registered Nurse and presented to the Medical Director for medical appropriateness prior to being accepted for admission. Pre-assessments will include a medical history, functional status, prior and current, any diagnostic testing, and functional goals for discharge. All patients deemed appropriate will be approved with the Medical Director’s signature prior to admission.

The initial nursing admission assessment will be completed within 8 hours of the patient’s admission and documented on the interdisciplinary form. The Registered Nurse will complete the initial admission assessment and the daily reassessment. Findings will be documented on the appropriate document and nurses’ notes in the permanent record.

2. Reassessment

An RN will complete a reassessment of patient each shift and after a change in patient’s level of care, as well as review care plans of patients. Each patient will be reassessed every shift by an RN or LPN, and any significant findings and/or changes in the patient’s status will be documented and reported to the attending physician and, when appropriate, to the members of the interdisciplinary team. Information will be collected on an ongoing basis to reflect the patient’s current level of care. Any patient discharged to another level of care will require new
assessment process through the intake referral office prior to return to inpatient rehab program to ensure medical stability.

X. Behavioral Health Services

1. Assessment – Upon admission, all patients shall be seen and evaluated by Registered Nurse. Family members, significant others, and other providers may be utilized, as appropriate to provide additional data.

An assessment of the patient will be completed within 4 hours of admission, and will take into consideration the following three factors:

a. The anticipated length of stay for the patient population served.
b. The complexity of the nursing care needs of the population served.
c. The dynamics of the condition of the major patient population served.

The nurse must consider appropriate patient information related to the following seven factors:

a. Biophysical
b. Biopsychosocial
c. Environmental
d. Self-care
e. Pain
f. Educational
g. Discharge planning

2. Reassessment – The registered nurse will reassess each patient’s condition at least once every shift and as indicated by significant change in their psychiatric or medical condition or diagnosis to determine physical and psychological status. This information will be documented in the medical record and will be utilized in the treatment of the patient. Reassessment determines patient response to care. Categories to be addressed regarding reassessment will include:

a. Potential for self-harm or harm to others
b. Special medical needs
c. Thought content
d. Mental status observation

Y. Functional Assessment (SpeechTherapy/Occupational Therapy/PhysicalTherapy/Cardiac Rehab)

1. Assessment (Acute Care)

Refers to the process of determining the need for, nature of, and estimated time of treatment, determining the needed coordination with other persons involved,
and documenting these activities. The initial assessment will be completed by each discipline, as ordered by physician, within 48 hours of receiving the referral. Data will be obtained and interpreted as needed to begin the necessary treatment process. Documentation will be recorded in the patient’s permanent record.

Outpatient Services

Patients will be assessed by a licensed therapist the day of the scheduled visit with documentation within 48 hours on the permanent record. Such procedures included but are not limited to the use of standardized tests, performance checklists, activities and tasks designed to evaluate specific performance abilities.

Rehabilitation Unit

All inpatients will be assessed within 48 hours of initial admission. Verification of therapy orders will be completed within 48 hours of admission. All documentation of initial assessment will be recorded on the interdisciplinary evaluation and placed in the patients’ permanent record.

2. Reassessment (Acute Care)

A reassessment refers to the process of obtaining and interpreting data necessary for updating treatment plans and goals. This frequently involves administering only portions of the initial assessment, documenting results, and/or revising treatment due to change in patient’s functional level. Reassessments will be completed, as needed reflecting any change in patient’s status. The physical therapist will perform reassessments of patient’s every 2 days in acute care or as specified with any change in the level of patient’s status and services required. Documentation will be recorded in the patient’s permanent record.

Outpatient Services

Patients will be reassessed every two weeks to reflect patient’s status changes, review goals and services needed or provided.

Rehabilitation Center

All inpatient rehab admissions will be reassessed ongoing and reported weekly. Results of the reassessment will be reported during weekly interdisciplinary team conferences with documentation of any revision of patient goals.
Y. Dialysis

1. Assessment

   All patients are assessed by an RN upon entry for pre-dialysis.

2. Reassessment

   Reassessment is completed throughout treatment by an RN and documented in the nursing notes. All patients are reassessed during dialysis and post-dialysis, and if the patient's condition changes, as specified in departmental policy.
ABBREVIATIONS

Policy: To maintain a list of common abbreviations for reference

A list of common abbreviations used at Coliseum Medical Centers will be maintained for reference. This list is not intended to be exclusive. It is the responsibility of all staff members to only execute orders which are legible and whose content, including the use of symbols or abbreviations, is within the policies and practice of the hospital.

Four lists are used
- Reference of Common Abbreviations
- Prohibited Abbreviations
- Symbols
- Decimal Use

DECIMAL POINTS

Zero leading decimal points should be used (correct = 0.125 / incorrect = .125)
Never use a zero after a decimal point (correct = 2 mg / incorrect = 2.0 mg)

APOTHECARY SYMBOLS may not be used
### UNACCEPTABLE ABBREVIATIONS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Potential Problem</th>
<th>Preferred Term</th>
</tr>
</thead>
<tbody>
<tr>
<td>U (for unit)</td>
<td>Mistaken as zero, four or cc.</td>
<td>Write &quot;unit&quot;</td>
</tr>
<tr>
<td>IU (for international unit)</td>
<td>Mistaken as IV (intravenous) or 10 (ten).</td>
<td>Write &quot;international unit&quot;</td>
</tr>
<tr>
<td>Q.D., Q.O.D. (Latin abbreviation for once daily and every other day)</td>
<td>Mistaken for each other. The period after the Q can be mistaken for an &quot;I&quot; and the &quot;O&quot; can be mistaken for &quot;I&quot;.</td>
<td>Write &quot;daily&quot; and &quot;every other day&quot;</td>
</tr>
<tr>
<td>Trailing zero (X.0 mg), Lack of leading zero (.X mg)</td>
<td>Decimal point is missed.</td>
<td>Never write a zero by itself after a decimal point (X mg), and always use a zero before a decimal point (0.X mg)</td>
</tr>
<tr>
<td>MS, MSO₄, MgSO₄</td>
<td>Confused for one another. Can mean morphine sulfate or magnesium sulfate.</td>
<td>Write &quot;morphine sulfate&quot; or &quot;magnesium sulfate&quot;</td>
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</tbody>
</table>
MEDICATION ADMINISTRATION

Administration of Medications

Medications are administered to patients only upon an order from a physician who is a member of the Medical Staff. They may be administered by Physicians, Registered Nurses, Licensed Practical Nurses and Respiratory Therapists. Student nurses and therapists from affiliated schools may administer medications under the supervision of their instructors. Radiology techs may administer contrast media. Nuclear medicine techs may administer radioactive contrast media.

Non-physicians (e.g., Registered Nurses, LPNs, Radiology Techs, and Nuclear Med Techs) who administer IV medications shall require specialized training to be qualified to administer IV medications. Until competency skills for administering IV medication have been performed, staff administering IV medication shall only administer IV meds under the supervision of one who has completed specialized training and IV medication skills have been validated. IV medication administration skills are validated and evaluated by competency skills checklist.

Routine drugs are administered as ordered by the physician according to assigned schedule. All administered medications must be entered into the patient's record. This includes medications that are administered in error and medications administered by physicians.

The order will include the name of the drug, the dosage and the frequency of administration, the route of administration and the date, time and signature of the prescriber. Orders for drugs should be written by the prescriber. Verbal orders for drugs shall be given only to individuals so authorized by law and hospital medical staff, and only by a person lawfully authorized to prescribe, and will be recorded promptly in the patient's medical record, noting the name of the individual receiving the order.

Individuals allowed to take verbal orders are listed below:
1. Registered Nurse
2. Licensed Practical Nurse
3. Physical Therapist for physical therapy orders
4. Respiratory Therapist for respiratory therapy orders
5. Dietitians for diet orders
6. Pharmacist for pharmaceutical orders

Routine drugs are administered as ordered by the physician according to assigned schedule. In administering analgesic drugs documentation will include:
1. Need
2. Location of administration (right deltoid, left deltoid, etc.)
3. Location of pain (operative side, right shoulder)
4. Evaluation of effectiveness
For further information concerning ordering of drugs, etc., refer to the Procedure Manual and to the Pharmacy Manual. Standard hours for medication administration have been developed for Coliseum Medical Centers. The following categories of medications are administered within the time frames stated:

**STAT** – medication is administered within 15 minutes of order written.

**ROUTINE** - medication is administered within a time frame of 30 minutes before and 30 minutes after the scheduled dose time.

**New Medication** – Medication is administered at the next scheduled dose time; as soon as possible.

Delayed and omitted medications can be determined as justified when:
- Patient was NPO
- Patient was temporarily absent from the patient care unit (scheduled procedure)
- Patient refused doses
- The reason for the delay or omission of a medication will be documented on the MAR

All medications will be administered after verifying the 5 patient rights:
1. Right Patient
2. Right Route
3. Right Medication
4. Right Time
5. Right Dose

In addition to verifying the 5-Rights:

1) The person administering the medication remains with the patient until the medication is administered;
2) Administration is within 30 minutes of the scheduled time for administration;
3) Prior to administration, patient identity is verified using 2 identifiers (one of which cannot be the room number);
4) The medication’s stability is verified based on visual examination;
5) Contraindications are reviewed;
6) The patient or family is advised of potential clinically significant adverse reactions or other concerns regarding new medication;
7) Unresolved, significant concerns about the medication is discussed with the patient’s physician and other relevant staff involved in the patient’s care.
**IV Medications, IV Fluids, Blood and Blood Components**

Registered Nurses who have demonstrated competency may:

- Perform Venipuncture
- Regulate IV fluids
- Administer IV Medications
- Start IV Fluids
- Administer Blood and Blood Products
- Administer IV fluids containing medications

Additional training and competencies are required to administer Chemotherapeutic agents. These agents are administered by IV infusion. Licensed Practical Nurses who have demonstrated competency may:

- Perform Venipuncture
- Administer selected IV Medications via IVPB
- Start selected IV fluids
- Administer selected medications via IV push
- Administer selected IV fluids containing medications
- Regulate certain IV fluids

IV Medications and Products that **May Not** be administered by a Licensed Practical Nurse on the Med/Surg floor are as follows:

- Blood and Blood Products
- Cardiac Medications: Lopressor, Vasotec, Cardizem, Adenocard, Natrecor
- Chemotherapy

The Registered Nurse may elect not to administer a particular IV medication due to her professional judgment.

1. The nurse may determine the patient has very difficult veins.
2. The nurse may regard the particular drug as being extremely potent and of a serious enough nature to warrant help in the administration, either from the administrative supervisor or the physician.

Record of knowledge and ability to perform venipuncture is recorded on the employee skills list. Only those Nurses who are qualified are allowed to perform this procedure.

**Administration Times**

Each practitioner who prescribes medication must clearly state the administration times or the frequency of doses. The terms "prn" and "on call" must be qualified (i.e. q 4 h prn pain and on call to OR) so that there is no question as to the intent of the prescriber.
The standard hours for medication administration with set time of administration will be approved by the Medical Staff. Unless otherwise designated by the physician’s order, a nurse or pharmacist may make adjustment of the times to:

1. accommodate administration of multiple medications,
2. prevent food-drug/drug-drug interactions,
3. coincide with the time the patient routinely takes the medication at home,
4. enhance the safe, effective, and/or efficient use of the medication.

**Medications Brought in by Patients Upon Admission**

**Security:** If a patient brings medications to the hospital on admission, staff should attempt to find a responsible family member to take the medications home. If that is not possible, home medications belonging to the patient may be sent to the pharmacy until arrangements can be made or the patient is discharged. Medications must be inventoried on the “Custody of Home Medications” form. The patient or representative should sign indicating that the pharmacy will secure the medications as a courtesy until arrangements can be made or the patient is discharged. The medications should be put in a sealed bag and sent with the custody form to the pharmacy. A copy of the custody form should be given to the patient and a copy placed on the chart as a reminder that the patient has requested their medications be secured in the pharmacy. When the patient is ready for discharge or has made arrangements with a family member to take the medications on behalf of the patient, nursing should request the medications from the pharmacy. The nurse will sign for receipt of the medications, and have the patient sign the custody form verifying receipt of all medications on the inventory sheet. The completed custody form should be put in the chart as a permanent part of the record. Medications that are not picked up by the patient will be destroyed 30 days after discharge.

**Administration of Medications brought from home:** If it is requested that medications brought into the hospital by patients be self-administered or staff administered, the following must be complete and documented:

1. The medication provided is confirmed by the pharmacist or the physician as being the correct medication requested.
2. There is a physician order stating that the patient or staff should administer the medication.
3. The medications are stored in a secure place (not in the patient’s room).
Self-Administered Medications

Self-administration of drugs by patients shall be permitted only when specifically authorized by the treating or ordering physician, provided that the patient has been educated and trained in proper self-administration and there is no risk of harm to the patient. Nursing personnel are responsible for documenting that these medications are being self-administered.

Automatic Stop Orders and Medication Renewal

Antibiotics and Schedule II controlled substances written for an exact number of doses will be administered as such; however, when no time or dose limitation is specified on the original order, the following automatic stop order will be initiated:

- Schedule II Narcotics: 4 days
- Antibiotics: 10 days
- Hypnotics: 7 days
- Ketorolac (Toradol): 5 days
- All other drugs: 30 days

The patient care plan should be checked daily for renewal dates on narcotics and antibiotics that have been ordered without time limitations and dosage. The list of drugs to be renewed should be placed on the front of the chart twenty-four (24) hours prior to the expiration date.

Investigational Drugs

Investigational drugs may be administered following protocols approved by Coliseum Medical Centers’ Institutional Review Committee.

Medication Use and Route of Administration

Medications prescribed should be used for a FDA approved indication and dose and in a FDA-approved route of administration or as an accepted standard of practice. Medications used for any indication, dose, or route that is not approved must be documented by a scientific journal or articles as appropriate for indication or route for which the drug was prescribed (i.e. Medical Letter, Micromedex, etc.).

Patient Allergies

Before dispensing medications, the Pharmacy must be notified of any allergies the patient may have or indicate that there are no allergies or NKA (no known allergies). This information must be sent to the Pharmacy as soon as possible after admission. Before administering any medications, the patient must be questioned regarding allergies and the chart checked for documentation of known medication allergies/sensitivities.
Medication Errors
(See Hospital Wide Policy for Medication Errors)

Adverse Drug Reactions

1. Definition

   An adverse drug reaction (ADR) is: "Unintended, undesirable, and/or unexpected effects of prescribed medications or of medication errors that require discontinuing a medication or modifying the dose; require initial or prolonged hospitalization; result in disability; require treatment with a prescription medication; result in cognitive deterioration or impairment; are life threatening; result in death; or in congenital abnormalities.

   A significant adverse drug reaction requires discontinuation of the medication, adjustment of the dose, or the requirement of additional medication as treatment. Examples include:
   a. Symptoms suggesting an allergic reaction: rash, pruritus, anaphylaxis, edema, wheezing, or laryngospasm,
   b. Severe GI disturbances: vomiting, diarrhea,
   c. Severe skin or mucosal changes: ulcers, Stevens-Johnson syndrome,
   d. Changes in mental status: hallucinations, confusion, anxiety, etc.
   e. Systemic changes: hypertension, hypotension, respiratory distress, hematologic,
   f. CNS, cardiovascular, or respiratory instability,
   g. An adverse event that is potentially life threatening or actually results in death.

An ADR resulting in death, paralysis, coma or other major permanent loss of function may qualify as a sentinel event and must be reported to Risk Management.

(See Hospital wide policy for Reporting Adverse Drug Reactions)

Prescriptions:

Prescriptions for take-home medications must be signed by the physician.

Narcotics (Controlled Drugs):

1. Drugs must be counted at shift change with on-coming and off-going nurse and signatures placed as to correct count on the “narcotic control sheet.
2. Controlled drugs must be signed out in full with date and time.
3. Physician’s first initial and last name must be filled in.
4. Nurse administering the controlled drug must sign full name and title- RN or LPN.
5. Nurses must not sign out for each other on control sheet nor chart narcotics for each other.

6. If a patient refuses a prepared dose of a controlled drug or if the drug is not administered for some other reason, the prepared dose of controlled medication must be returned to the Pharmacy for disposal. This medication is disposed of by representatives from the Narcotics Agency.

7. Documentation of medication in the patient record must coincide with the time and date of the “narcotic control sheet”.

8. Controlled drugs cannot be transferred from one nursing unit to another. These drugs are logged out to the units that sign out for them and that unit is responsible for them. If controlled substances are needed on a nursing unit, the pharmacist should be called to issue the drugs.

9. When less than the whole unit dose of a controlled drug is administered, the nurse administering the partial dose must waste the remaining medication in the presence of a second nurse. Both nurses must then co-sign the narcotic sheet in the appropriate place.

Labeling of Medication:

All labeling pertaining to drug containers will be done by the Pharmacy Department or the manufacturer of the drug or solution.

Nurse will return to Pharmacy any drug or chemical solution that is not labeled according to the above policy.

A Pharmacist is the only person permitted to remove a drug or chemical solution from one container and place it in another.

Nursing Staff will not alter labels in any way, or replace them with adhesive tape.

Medications/Treatments – Discharge Patients:

1. Patients on whom discharge orders are written will continue to receive medications and treatments as ordered until actual time of discharge.

2. Medications not administered will be returned to the Pharmacy.

3. In rare and special cases, some medication may be sent home with the patient. The physician must write a prescription for the patient to take the medication home. The medication must be returned to the Pharmacy and labeled and dispensed according to GA law prior to issuing to the patient.

Dispensing of Medications:

A physician or pharmacist must perform the act of dispensing. Nurses may only administer drugs pursuant to a physician’s order; they may not dispense.

In order to clarify and differentiate between the two functions, the definition of each follows:
“Administration” shall mean the giving of a unit dose of medication to an individual patient as a result of the order of an authorized practitioner of the healing arts.

“Dispensing” shall mean the issue of one or more doses of medication in a suitable container with appropriate labeling for subsequent administration to, or use by a patient.

**Medications – Refusal to Administer:**

The nurse has the right to refuse to give any drug he/she feels is inappropriate for him/her to administer. The Nursing Supervisor must be notified.

**Needle Disposal:**

Entire used needle and syringe are disposed of in an impervious needle disposal box. All patient rooms are equipped with these boxes. It is the responsibility of Nursing Department employees to replace boxes as they become filled. This used container is then placed in the “red” incinerator trash bag.

**Emergency Medications:**

Emergency medications are available, controlled and secure on patient care areas. (See Crash Cart Maintenance Policy).

**Multi-dose Vials:**

All multidose vials must be dated when punctured for the first use. The contents of the vial expire after 28 days from that date unless otherwise specified by the manufacturer. If a multidose vial is discovered opened and undated or the date opened is illegible, it should be discarded and a new vial obtained.
MONITORING FOR TRANSFUSION REACTIONS

A Registered Nurse must remain with the patient for the first fifteen minutes and observe closely for any adverse reactions.

Signs and/or symptoms of adverse reaction
- Temperature $\geq 39^\circ C$ or $\geq 102^\circ F$. Temperature rise from pre-transfusion $\geq 2^\circ C$ or $\geq 3.5^\circ F$
- Chills
- Tachycardia: Heart rate $\geq 120/min$ or $\geq 40/min$ rise from pre-transfusion rate.
- Systolic blood pressure:
  - Rise $\geq 30$ mm Hg or
  - Drop $\geq 30$ mm Hg from pretransfusion BP
- Shortness of breath
- Severe back pain
- Headache
- Nausea and vomiting
- Hives (urticaria)
- Shock
- Pain at infusion site, chest, abdomen and/or flanks
- Urine color changes

In the event of a possible reaction:
- Stop the transfusion immediately and click “Hold” or “End” on Status Board.
- Maintain IV line with normal saline and new IV set. Administer IV fluids to achieve urine output of 100 ml/hr to help prevent renal failure.
- Clamp transfusion set with hemostat near bag outlet prior to removal from patient.
- Notify physician, clinical supervisor and blood bank
- Monitor vital signs every fifteen minutes
- Place the patient on oxygen if supplemental flow is not being given.
- Return blood bag and tubing to Lab in a biohazard bag with a copy of the blood product requisition attached.

- In Status Board click “Reactions”. Press <Enter> (or correct date/time), then “OK”. Always select “BBKSTXN” (Suspected transfusion reaction) only, then “OK” & review instructions. Press <Enter> & enter signs & symptoms as appropriate.
- Order Transfusion Reaction workup in Meditech completing all required fields and/or queries:
  a In “Category”, enter BBK.
  b Under “Procedure” enter “TRXN.”
  c This order is to be placed if a transfusion reaction is documented.
RETURNING UNITS TO THE BLOOD BANK

After completed infusion, blood bag should be retained on unit for 90 minutes. If the patient has no signs of reaction, the blood bag may then be discarded in red biohazard container. Blood signed out and returned may be accepted and/or reissued by the blood bank technician if the following conditions are met.

- The container has not been entered
- The unit has been signed out for 30 minutes or less and is still cold
- If the unit was issued and remained on ice
  - If the temperature monitoring device does not indicate the unit exceeded temperature requirements.

When blood is released to the floor, the transfusion should begin within 30 minutes. If additional time is required, the unit should be returned to the blood bank until the appointed transfusion time. A transfusion should be completed within 4 hours.
MEDICATION ERROR REPORTING POLICY

I. PURPOSE
   To establish a comprehensive, non-punitive, systems-based approach to the identification, reporting, analysis and management of medication variances.

II. POLICY
   A. The hospital supports a confidential, non-punitive, systems-based approach to the identification and reporting of medication variances.

   B. Medication errors are reported by entering directly into the facility’s Occurrence Notification System (CPCS Risk Module) by one who observed the incident or to whom the occurrence was reported.

   C. Medication errors are reported to the medical staff through the Patient Care Committee at the scheduled bimonthly meeting. The medical staff and Risk Management are responsible for overseeing performance improvement measures to reduce the incidence and frequency of these events.

   D. A systems-based approach will be used to analyze medication variances to identify failures in systems and processes.

   E. All documents related to Medication Errors and Data Analysis of these reports will be subject to the organization’s peer review process and will be used for Performance Improvement activities as set forth in this policy.

   F. Employees will be trained on medication safety and the Medication Error Reporting Program upon employment and on an annual basis.

III. PROCEDURE
   Reporting an Actual Medication Error

   a. Incidents are documented by utilizing the Occurrence Notification System (Risk Module of CPCS) by one who actually observed the incident or one to whom the incident was reported.

   b. A Nursing Supervisor or Department Manager should be notified to evaluate the situation and to assess the need for immediate medical attention.

   c. Notify the Patient’s Attending Physician of the event.

   d. If the Patient or Visitor is seen by a Physician for evaluation following the incident, the Physician’s findings are to be documented in the “Corrective Actions” section of the Occurrence Notification.
e. A Visitor requesting or requiring medical attention is to be evaluated by the Nursing Supervisor and then escorted to the Emergency Room.

f. If the individual refuses medical attention, indicate this on the Occurrence Notification.

g. When completing the Occurrence Notification, take care to include all details concerning the incident, identifying potential witnesses and employees, the area in which the incident occurred, lighting, any obstructions to vision or walking, etc.

h. After completion of an Occurrence Notification, a Unit Manager/Department Director/Nursing Supervisor should be notified for review and follow up. *Early intervention can not occur if occurrences are not reported in a timely fashion. Occurrence notification should take place as soon as an event is discovered.

i. The Risk Manager is to be notified immediately of any event involving a Patient or Visitor which could result in a potential claim involving the Health Care System. This notification should be accomplished by telephoning (leave message) or paging for the Risk Manager to discuss the event. Pictures of the site may also be important to the investigation. If the Risk Manager cannot be reached, Administration and/or Quality Management should be notified.

j. The Risk Manager and/or her/his designee will review all Occurrence Notifications for completeness & accuracy and for documentation in the patient’s chart, if applicable.

k. Occurrence Notifications will be classified by severity.
Risk Management Plan

PURPOSE
With a commitment to provide quality health care, and to assure the continuing human, physical and financial integrity to provide it, Coliseum Medical Centers’ Risk Management Program will establish a program of activities to minimize the adverse effects of loss through:

- Identification and assessment of loss potential
- Loss prevention
- Loss funding and risk financing
- Claims control

Coliseum Medical Centers has established a Risk manager to direct, supervise and manage the program to oversee its effectiveness throughout the hospital.

POLICY
Coliseum Medical Centers shall maintain a comprehensive Risk Management Program in accordance with the rules and regulations of the Georgia Department of Health and Human Services, Medicare Conditions of Participation, JCAHO Standards, and other regulatory agencies. The program operates with the support and under the authority of the Board of Trustees through the approval of this plan.

It is the policy of Coliseum Medical Centers to reduce, modify, eliminate, and control conditions and practices that may cause loss while keeping the safety and well-being of the patients, personnel and public a top priority.

SCOPE OF PROGRAM
The Risk Management Program includes all departments, services and health care professionals of Coliseum Medical Centers. The program includes and/or integrates the following components:

- Loss Control
- Risk Assessment
- Safety Management
- Performance Improvement
- Credentialing
- Retention of Records
- Confidentiality of Information
- Patient Relations
- Claims Management

The Risk Management Program considers potential risks to all ages (infant, child, adolescent, adult and geriatric), and attempts to reduce risks in the hospital’s high-risk areas. Coliseum Medical Centers upholds both its legal and ethical responsibility to provide safe and optimal quality patient care, while ensuring a safe environment for patients, employees, physicians, and visitors.
OCCURRENCE NOTIFICATION REPORTING

Purpose:
The occurrence and close call reporting system (Risk Module of Company Clinical Patient Care System = CPCS) utilized at Coliseum Medical Center is one of the tools used to identify and analyze, correct, and follow-up on occurrences which happen within the health care environment. This system is in place to ensure timely receipt, review, close calls, classification and follow-up of all Notifications. This System is used for identifying situations which may pose a risk or hazard to patients, visitors, physicians and employees, and provides a very important mechanism for communicating needed information to the appropriate personnel responsible for correcting identified problems, as well as to those involved in Risk Management who attempt to monitor all incidents in an effort to reduce the possibilities of risks and hazards and improve quality of patient care & services.

Definition of an occurrence:
An occurrence is defined as an unusual event, which transpires in or on the premises of the hospital or health care environment. The event is considered unusual if the result was unexpected, unintended, undesirable, and/or departs from Coliseum Medical Center’s standard of conduct or practice. Occurrences may not be limited to patient care. Report any disturbance that occurs that does or may disrupt operational functions of which may affect the standing of the health care facility in the community. Visitor, employee and other customer encounters are considered when reporting occurrences. A significant violation of established policy & procedure is a reportable occurrence. Also, occurrences are defined as observed or alleged physical abuse of a patient. Any threat of personal harm or injury to patient, visitor or staff member is also considered when defining an occurrence. Injury occurrences may range from minor sprains/strains to organ injury during a surgical procedure. There are other common occurrences that need reporting: falls, medication errors, transcription errors, delay in tests, treatments or procedures, mislabeled specimens, inappropriate behavior, etc. The deciding factor should be whether the event poses a potential risk that should be brought to management’s attention in order that any needed review for corrective activity may occur.

Close Call:
A “close call” is an unplanned incident that does not cause injury or harm to people or property but under different circumstances could have. It serves as a reminder of what needs to be done differently next time to ensure everyone’s safety.

Hospital Liability:
Liability on the part of the Hospital is not automatically implied in the event of a Patient or Visitor Occurrence. Therefore, while concern should be expressed to ensure the involved individual receives prompt medical attention when indicated, caution should be exercised when discussing the responsibility for the medical expenses. Misrepresentations of responsibility, no matter how well intended, can result in the individual feeling confused and angry should all facts surrounding the incident indicate that the Hospital was not at fault for the occurrence. The responsibility for payment of medical expenses are to be handled only by the Risk Manager and/or Hospital/Facility Administrator.

Procedure:
1. Incidents are documented by utilizing the Occurrence Notification System (Risk Module of CPCS) by one who actually observed the incident or one to whom the incident was reported.
2. A Nursing Supervisor or Department Manager should be notified to evaluate the situation and to assess the need for immediate medical attention.
3. Notify the Patient’s Attending Physician of the event.
4. If the Patient or Visitor is seen by a Physician for evaluation following the incident, the Physician’s findings are to be documented in the “Corrective Actions” section of the Occurrence Notification.
5. A Visitor requesting or requiring medical attention, is to be evaluated by the Nursing Supervisor and then escorted to the Emergency Room.
6. If the individual refuses medical attention, indicate this on the Occurrence Notification.
7. When completing the Occurrence Notification, take care to include all details concerning the incident, identifying potential witnesses and employees, the area in which the incident occurred, lighting, any obstructions to vision or walking, etc.
8. After completion of an Occurrence Notification, a Unit Manager/Department Director/Nursing Supervisor should be notified for review and follow up. *Early intervention can not occur if occurrences are not reported in a timely fashion. Occurrence notification should take place as soon as an event is discovered.
9. The Risk Manager is to be notified immediately of any event involving a Patient or Visitor which could result in a potential claim involving the hospital.
   This notification should be accomplished by telephoning (leave message) or paging for the Risk Manager to discuss the event. Pictures of the site may also be important to the investigation. If the Risk Manager cannot be reached, Administration and/or Quality Management should be notified.
   The Risk Manager and/or her/his designee will review all Occurrence Notifications for completeness & accuracy and for documentation in the patient’s chart, if applicable.
10. Occurrence Notifications will be classified by Severity.

THINGS TO REMEMBER WHEN CHARTING AN OCCURRENCE:
A. DO NOT chart that an Occurrence Notification has been completed.
B. State the facts of the incident, along with the names and times of people you notified (nursing supervisor, MD, etc.).
C. Chart any effects (if any) that the incident had on the patient.
D. Chart if any follow-up tests and/or treatments ordered and if they are initiated.
WHEN TO COMPLETE AN OCCURRENCE NOTIFICATION REPORT:

The responsibility for completing an Occurrence Notification rests with any hospital or health facility staff member who witnesses, discovers or has direct knowledge of an occurrence, as previously defined. Any additional staff members who witness, discover or have direct knowledge of the occurrence are required to submit a supplement to the Occurrence Notification.

An Occurrence Notification must be completed for any of the following circumstances:
1. A disturbance occurs that does or may disrupt hospital functions or which may affect the standing of the health care facility in the community.
2. An undesirable event occurs which is inconsistent with normal patient care.
3. A significant violation of established policy and procedure occurs.
4. An unusual event occurs which does or may result in personal and/or bodily injury.
5. An event occurs which, by standards was unexpected and/or unintended.
6. Damage to facility property or reputation.
7. Any occurrence involving hostility voiced by a patient, visitor or family member (requires verbal communication to the Hospital Risk Manager in addition to completing a Notification).
8. Any threat of personal harm or injury voiced by a patient, visitor or family member, which requires precautionary actions be taken.
9. Failure to obtain a proper consent for admission, consent for treatment, or release of confidential information in violation of hospital procedures, State Mental Health Code or Federal Confidentiality Act.
10. Failure to discharge a patient who has requested discharge in violation of established procedures in the State Mental Health Code.
11. Utilization of restraint and/or seclusion in violation of established hospital policy and State Mental Health Code.
12. Observed or alleged physical abuse of a patient by any staff member.
13. Any alleged sexual, personal and/or financial business relationship of any kind between a staff member and a patient and their families who are currently being treated.
15. Close calls where injury did not occur but under different circumstances could have.

*The deciding factor should be whether the event poses a potential risk that should be brought to management’s attention in order that any needed review for corrective activity may occur.*
Patient Rights

Coliseum Medical Centers presents these Patient's Rights with the expectation that observance of these rights will contribute to more effective patient care and greater satisfaction for the patient, his physician, and the hospital. In the case of neonate, child and adolescent, these rights are extended to the parent or legal guardian.

It is the policy of Coliseum Medical Centers to provide equal services to all individuals without regard to race, color, sex, religion, national origin, ancestry, age, marital status, handicap, disability or expectation of reimbursement.

PATIENT RIGHTS

1. The patient has the right to considerate and respectful care in a setting that is safe and free from all forms of abuse and harassment.

2. The patient has a right to participate in the development and implementation of his or her plan of care.

3. The patient has the right to obtain from his physician complete current information concerning his diagnosis, treatment, and prognosis in terms the patient can be reasonably expected to understand. When it is not medically advisable to give such information to the patient, the information should be made available to an appropriate person on his family. He has the right to know by name the physician responsible for coordinating his care.

4. The patient has the right to have a family member or representative of his/her choice and his/her own physician notified promptly of their admission.

5. The patient has the right to receive from the physician information necessary to give informed consent prior to the start of any procedure and/or treatment. Except in emergencies, such information for informed consent should include but not necessarily be limited to the specific procedure and/or treatment, the medically significant risk and the probable duration of incapacitation. Where medically significant alternatives, care or treatment exist, or when the patient requests information concerning medical alternatives, the patient has the right to know the name of the person responsible for the procedures and/or treatment.

6. The patient has the right to refuse treatment to the extent permitted by law, and to be informed of the medical consequences of his action.

7. The patient has a right to formulate advance directives and have hospital staff and practitioners who provide care in the hospital comply with those directives.
8. The patient has the right to every consideration of his privacy concerning his own medical care program. Case discussion, consultation, examination, and treatment are confidential and should be conducted discreetly. Those not directly involved in his care must have the permission of the patient to be present.

9. The patient has the right to expect that all communications and records pertaining to care should be treated as confidential.

10. The patient has the right to access information contained in his/her medical record within a reasonable time for a reasonable fee.

11. The patient has the right to expect that within its capacity a hospital must make response to the request of a patient for services. The hospital must provide evaluation service, and/or referral as indicated by the urgency of the care. When medically permissible a patient may be transferred to another facility only after he has received complete information and explanation concerning the needs for and alternatives to such a transfer. The institution to which the patient is to be transferred must have accepted the patient for transfer.

12. The patient has the right to obtain information as to any relationship of his hospital to other health care and educational institutions insofar as his care is concerned. The patient has the right to obtain information as to the existence of any professional relationship with individuals by name, who are treating him.

13. The patient has the right to be advised if the hospital proposes to engage in or perform human experimentation affecting his care or treatment. The patient has the right to refuse to participate in such research projects.

14. The patient has the right to expect reasonable continuity of care. He has the right to know in advance what appointment times and physicians are available and where. The patient also has the right to expect that the Hospital will provide a mechanism whereby he is informed by his physician or a delegate of the physician of the patient’s continuing health care requirements following discharge.

15. The patient has the right to examine and receive an explanation of his bill regardless of sources of payment.

16. The patient has the right to know what hospital rules and regulations apply to his conduct as a patient.

17. The patient has the right to express verbal or written complaints concerning his/her care and to expect timely resolution and feedback regarding those complaints.

18. The patient, and when appropriate, their families have the right to be informed about the outcomes of care including unanticipated outcomes.
19. **When clinical ethical issues arise, the facility will address these type situations. In the event of clinical ethical dilemma and/or difficulty in decision-making, you have the right to request assistance. The hospital respects and provides for each patient’s right to pastoral counseling.**

20. The patient has the right to appropriate assessment and management of pain. The hospital plan, supports, and coordinates activities and resources to assure the patient’s pain is recognized and addressed appropriately. This includes initial assessment and regular reassessment of pain; education of all relevant providers in pain assessment and management; education of the patient and/or family regarding their roles in managing pain as well as the potential limitations and side effects of pain treatments; and while taking into account the patient’s personal, cultural, spiritual, and/or ethnic beliefs, communicating to the patient and/or family that pain management is an important part of care.

21. The dying patient has the right to comfort and dignity through treatment of primary and secondary symptoms that respond to therapies as desired by the patient or surrogate decision-maker. Psychological and spiritual concerns of the patient and the family regarding dying shall be acknowledged along with his/her individual and corporate expression of grief.

22. The right to be free from restraints of any form that are not medically necessary or are used as a means of coercion, discipline, convenience or retaliation by staff.
PAIN: Assessment, Management, and Documentation Policy

Coliseum Medical Centers (CMC) healthcare team recognizes that pain can be a common part of the patient experience and that unrelieved pain has adverse physical and psychological effects. The patient’s right to pain management is respected and supported. Services for patients are provided in such a way as to respect and foster their sense of dignity, autonomy, positive self-regard, civil rights and involvement in their own care. The ethical obligation to manage pain and relieve the patient’s suffering is at the core of a health care professional’s commitment. The health care professionals of Coliseum Medical Centers utilize an interdisciplinary approach to the management of pain in order to minimize or eliminate pain throughout the continuum of care.

The patient will have access to the best level of pain relief that may safely be provided. It is the policy of CMC to improve the practice of caregivers in the recognition, assessment, and management of pain throughout the hospital system to minimize pain experienced by patients during their hospital stay. CMC collects outcome data to monitor the appropriateness and effectiveness of pain management. CMC uses a variety of ways to obtain outcomes data from individuals served and their family members about specific needs and expectations; their perceptions of how well CMC meets these needs and expectations; and how CMC can improve. (Chart audits, CMC PI Plan and Patient Satisfaction Survey). The health care team will institute a plan of care to reduce pain in order to facilitate patient comfort, speedy recovery, lessen complications, lessen disability and improve quality of life.

Acute and chronic pain can be described as follows:

**ACUTE PAIN**

1. Mild to moderate to severe
2. Have a beginning and an end
3. Duration < 6 months
4. Readily described by patient
5. Narcotics – short courses
6. Managed with non-narcotics such as Tylenol, NSAID, Motrin, Naprosyn

**CHRONIC PAIN**

1. Persistent or episodic
2. Cause not always resolvable
3. Does not have a beginning or end
4. Duration > 6 months
5. Treatment requires frequent evaluation.

**Goal:** improve or stabilize patient performance status
Patient of all ages and settings at Coliseum Medical Centers have the right:

A. to express their pain and have that expression accepted and respected as the most reliable indicator of pain,
B. to have their pain assessed systematically and thoroughly,
C. to have their pain managed according to the most currently accepted methods,
D. to receive a prompt response to unrelieved pain, and
E. to be informed and involved in decisions regarding aspects of their pain care including their roles in managing pain as well as the potential limitations and side effects of pain treatments.

**PROCESS:**

A. Patients/families/caregivers will be informed at the time of the initial interview/assessment that effective pain relief is an important part of their treatment, that their report of unrelieved pain is essential, and that staff will respond quickly to their report of pain.

B. Patients/families/caregivers will be educated, when appropriate, regarding their roles in managing pain as well as the potential limitations and side effects of pain treatments. Staff will utilize an awareness of pharmacological interactions that may alter the effectiveness of the pain medication. Staff will consider psychosocial issues and possible need for antidepressants.

C. Patients/families/caregivers will be taught to use an age, condition, and language appropriate pain rating scale to report pain intensity. Observed behaviors will be utilized as a primary assessment method for the nonverbal child or adult, and the mentally impaired. The patient’s age, culture, developmental status, physical, emotional or cognitive condition and preference will be considered in developing a treatment plan.

Behaviors observed by nurses to assist in determining pain intensity:

<table>
<thead>
<tr>
<th>Movement</th>
<th>Verbal Cues</th>
<th>Facial Cues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Restless</td>
<td>Crying</td>
<td>Grimacing</td>
</tr>
<tr>
<td>Immobility</td>
<td>Moaning</td>
<td>Wincing</td>
</tr>
<tr>
<td>Decreased Movement</td>
<td>Whimpering</td>
<td>Strained look on face</td>
</tr>
<tr>
<td>Agitation</td>
<td>Screaming</td>
<td></td>
</tr>
<tr>
<td>Afraid to move</td>
<td>Grunting</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Emotion cues/mood</strong></td>
<td><strong>Positioning</strong></td>
<td><strong>Other</strong></td>
</tr>
<tr>
<td>Anxiety</td>
<td>Guarding</td>
<td>Diaphoretic</td>
</tr>
<tr>
<td>Fear</td>
<td>Fetal Position</td>
<td>Increased BP</td>
</tr>
<tr>
<td>Angry</td>
<td>Holding self rigid</td>
<td>Increased heart rate</td>
</tr>
<tr>
<td>Irritable</td>
<td>Splinting site of pain</td>
<td></td>
</tr>
<tr>
<td>Labile emotion</td>
<td>Tense</td>
<td>Pupil dilation</td>
</tr>
<tr>
<td>Apprehension</td>
<td>Stiff</td>
<td></td>
</tr>
<tr>
<td>Restlessness</td>
<td>Jumps when touched</td>
<td></td>
</tr>
</tbody>
</table>
D. When patients are taught to use the pain rating scale, they will be asked to set a comfort (pain relief) goal. The comfort goal is articulated in terms of function and quality-of-life parameters. The comfort goal and related patient teaching will be documented in the patient's medical record.

E. At the time of initial evaluation and at least once every shift patients will be asked about the presence and intensity of pain. Patients with pain initially or surgical patients will be re-evaluated as needed. The initial pain assessment will include pain intensity and quality including character, frequency, location, onset and duration, aggravating and alleviating factors, effects of pain on function and quality of life, and response to past interventions. The scope of assessment and treatment is based on the care setting and services provided. A more comprehensive assessment is performed when warranted by patient condition.

F. A pain rating greater than the patient’s comfort goal will trigger an appropriate pain relief intervention.

G. Pain intensity will be assessed within one (1) hour after medications are administered.

H. Pain ratings that are persistently above the comfort goal will trigger an interdisciplinary review of the pain management plan.

I. Staff will recognize that the elderly are at particular risk for both under and over treatment and that they report pain differently and may metabolize medications differently.

J. Staff will be aware of visual, hearing and motor impairments in all age groups that may impede the use of some tools in the assessment of pain.

**ASSESSMENT:**

**Tools:**

A. **Wong Baker Faces Pain Rating Scale**

   1. Considerations
      a. This pain scale will be used for patients with impaired cognition and communication through observation of facial characteristics OR asking the pediatric patient (recommended for 3 years or older) to describe which face compares with how they feel.
      b. This pain scale consists of 6 faces ranging from 0 = smiling face, no pain, progressing to 10 = a tearful face for excruciating pain.

   2. Procedure
      Explain to the patient that each face is for a person who feels happy because he has not pain (hurt) or sad because he has some or a lot of pain. **Face 0** is very happy because he does not hurt at all. **Face 2** hurts just a little bit. **Face 4** hurts a little more. **Face 6** hurts even more. **Face 8** hurts a whole lot. **Face 10** hurts as much as you can imagine, although you do not have to be crying to feel this bad. Ask the patient to choose the face that best describes how he or she is feeling.
B. 0 -10 Numeric Pain Distress Scale
   1. Considerations
      a. This pain scale will be used to assess a patient’s pain level if they display
         appropriate cognitive and verbal skills.
      b. The Visual Analogue Pain Scale consists of a straight line with end points identified
         as 0=no pain and 10=worst pain imaginable.
   2. Procedure
      Explain to the patient that the scale ranges from 0 No Pain to 5 Distressing Pain to 10
      Unbearable Pain. Ask the patient to choose the numeric value that best describes how
      he or she is feeling.

C. Neonatal Infant Pain Scale
   1. Considerations
      a. The NIPS tool is used to assess behavioral parameters related to pain in infants
      b. The maximum score is 7
      c. Non-pharmacological methods such as sucking, swaddling, and lullaby music, etc.,
         should be used prior to or in conjunction with pharmacological interventions.
      d. The absence of overt responses may indicate that the infant is too ill to respond, or
         is sedated pharmacologically.
   2. Procedures
      a. Using the NIPS scale the RN/LPN evaluates the infant on each of the six indicators
         and add the score.
      b. Scoring is done by utilizing the table as an Apgar scoring system. Determine a
         score for each of the 6 categories (note only “Cry” has the ability for a “2” score.)
      c. Scores greater than 4 indicate the infant is experiencing pain and requires
         intervention.
      d. The infant will be re-scored after the intervention to assess for the effectiveness of
         the intervention.
AGE SPECIFIC CONSIDERATIONS IN ASSESSMENT OF PAIN:

A. Pediatrics Pain Assessment:

Pain assessment may be complicated by communication barriers (i.e. the child may be non-verbal, or refuses to give a self-report). Therefore, staff may need to rely on observation to assess pain. The following observations may indicate both the location and intensity of pain in pediatrics:

1. What the child is saying or doing:
   a. Facial expression
   b. Behavior
   c. Level of activity

   NOTE: Observation of what the child is doing provides information about the presence, severity and location of pain. Response to pain may be demonstrated by crying, making a “pain” face or by holding or rubbing where it hurts. Sleep or activity pattern may change.
2. How the child’s body is reacting:
   a. Muscle tension
   b. Posture
   c. Sweating
   d. Flushing
   e. Pallor
   f. Dilation of the pupils
   g. Changes in heart rate or respiratory rate

NOTE: Biological measurement of pain is nonspecific. Changes in heart rate, blood pressure, diaphoresis, and blood gases can indicate pain, anxiety or constipation. Caring for the child in pain requires frequent assessment and reassessment of the presence, amount, quality and location of pain.

B. Geriatric Pain Assessment

Pain in an elderly patient may be difficult to assess due to impaired communication, dementia, memory problems, sensory impairments, or depression. Assessment requires a multidimensional approach including pain history, physical examination, and functional and psychological evaluation. Non-specific signs and symptoms of pain in the elderly may include:

   a. facial grimaces
   b. bracing
   c. guarding
   d. rubbing
   e. restlessness
   f. tension
   g. decreased appetite
   h. negative vocalizations
   i. hitting
   j. anxiety
   k. sighing
   l. insomnia
   m. sadness or crying
   n. fright
   o. decreased activity
   p. making demands

NOTE: A patient exhibiting the above nonspecific signs or symptoms listed above should be evaluated to determine the cause. These same signs and symptoms may occur in the absence of pain. Various medical conditions and medications should be ruled out as a cause before a diagnosis of pain is considered. Other causes may include psychiatric disorder; seizure disorder; iatrogenic disorders; delirium caused by a medical condition; infection.

Obtaining a pain history in an elderly person with memory failures, sensory impairments or depression should be supplemented with information from family or caregiver.

PROCEDURAL PAIN:

Not all procedures are painful. The decision to provide analgesia during a procedure will be made on the basis of knowledge of the likelihood that the procedure produces pain. The primary goal is for the patient to
experience adequate pain relief during the procedure if required. Other goals include minimal or no anxiety and fear related to the procedure, ability to cooperate during the procedure, and a prompt, safe recovery from the effects of the procedure. To accomplish these goals caregivers will ensure that the patient understands the procedure and the pain management plan and also experiences safe and effective anxiety and pain control during the procedure and recovery period. See Departmental policies for specific procedures/pain management.

**MANAGEMENT:**

A. Administer and monitor pharmacological agents as ordered in the medical plan.

B. Consider pain control options that are appropriate for the patient, family, diagnosis and setting.

C. Be aware of side effects and drug interactions of various drug therapies that may influence the effect.

D. Adjustments in dose and frequency will be based on reassessment of pain relief, and the physician’s orders.

E. Instruct patient in the use of non-pharmacological interventions as appropriate.

   1. Relaxation techniques
   2. Massage therapy
   3. Remembering peaceful past experiences
   4. Music
   5. Rhythmic breathing
   6. Note changes in behavior, appearance activity level and vital signs.

F. **PRN Analgesia Orders:**

   *The use of dose ranges (e.g., Demerol 50-75mg) and dose intervals (e.g., Q4-6H PRN) for PRN medication orders is discouraged in this facility. The following procedure will be utilized by clinical staff to execute orders written in this manner.*

|   |   |   |   |   |   |   |   |   |   |   |
|---|---|---|---|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Mild Pain | Moderate Pain | Severe Pain |

**Variable Dose**

- The nurse will assess the patient’s pain and document it on the medical record.
- The lower dose in a dose range will be used if a patient’s pain is between 0-5 on the numeric scale.
- The higher dose in a dose range will be used if a patient’s pain is between 6-10 on the numeric pain scale.
- The pharmacist will enter the same dosing guideline into the computer for utilization on the MAR.
- A similar method will be used with Wong-Baker faces for pain assessment.

**Variable Interval**
- The lower interval (e.g., every 4 hours in a every 4-6 hour dose interval) will be used the minimum interval that the medication may be administered.
- The pharmacist will enter the lower interval guideline into the computer for utilization on the MAR.
- A similar method will be used with Wong-Baker faces pain assessment.

**Other PRN orders**
- Orders with a variable dose should always begin with the lower dose. If symptomatic relief is not obtained, then the next dose should be increased to the higher dose.
- The pharmacist will enter the lower interval guideline into the computer for utilization on the MAR.
- PRN orders must be written to include the symptom or indication for use (e.g., PRN pain, PRN fever) unless there is only one possible use for the medication (e.g., the only possible PRN use of *Dulcolax* is for constipation). PRN orders are only administered if the symptom or indication is present.
- Orders without a symptom or indication for use must be clarified by both Pharmacy and Nursing prior to dispensing and administration of the medication respectively.

**DOCUMENTATION:**

Pain assessment and reassessment will be documented on admission and throughout the patient’s hospitalization. This documentation may be found on the admission assessment, shift assessment, or the process intervention screens. If pain is present a pain goal will be established. Continued reassessment will occur, at least every shift, before and after medication administration and before and after non-pharmacological pain relief measures.
ADVANCE DIRECTIVES

PURPOSE:

It is the purpose of Coliseum Medical Centers to honor a patient's right to consent to, refuse, or alter treatment plans and the right to formulate advance directives.

DEFINITIONS:

An **Advance Directive** is a document in which the patient either states choices for medical treatment or designates one who shall make treatment choices if the patient should lose or not wish to exercise decision-making capacity. In Georgia, there are two types of Advance Directives:

**Living Will:** A document which tells health care providers whether or not you want life-sustaining treatments or procedures if you are in a terminal condition, coma or persistent vegetative state.

**Durable Power of Attorney for Health Care:** Appoints another person to make medical decisions should the patient become temporarily or permanently unable to make those decisions themselves.

INFORMING PATIENT OF RIGHTS/OPTIONS

Patients Designated to Receive Information:

- Adult Inpatients only (>18 years of age)
- All inpatient hospital patients
- Outpatients in a bed-CLI, Blood, RCR
- Observation patients

**Patient Rights in Making Health Care Decisions:** Patient will be informed of their rights in making health care decisions.

- The right to make their own health care decisions. This includes the right to decide what treatments to accept, refuse or discontinue.
- The right to be informed of their diagnosis, proposed treatments, risks and alternative treatments and procedures available.
- Prior to a procedure, the right to information to help decide whether they want the treatment or procedure performed. (Informed Consent)
- The right to formulate an Advance Directive. In Georgia, Advance Directives are Living Wills and/or a Durable Power of Attorney for Healthcare. A handbook is available for more information about Advance Directives.
- Patients are not required to have an Advance Directive and will receive medical care regardless of the presence of an Advance Directive. In the absence of an Advance Directive, they retain the right to decide what medical treatment to accept, decline or discontinue.
- It is the patient’s responsibility to discuss these decisions with their physician for entry into the medical record.
Patient Acknowledgment of Rights

- During the admission or pre-admission process, the admitting clerk will ask the patient if they have an advance directive. This will be documented on the Condition of Admission form or Consent for Outpatient Services Forms.

If the patient is unable to answer for themselves
A family or significant other may be asked if they are aware of whether the patient has an Advanced Directive. This individual will be asked to complete the "Advance Directive Acknowledgment" form. If an advance directive is provided by another individual it should be copied and placed on the medical record. The original should be returned.

Duplicate unsigned documents will be placed in an envelope in the patient's chart in the event the patient becomes able to participate in his medical decisions. At that time, the patient will be visited by a representative from the Business Office who will go through the admitting process and have the patient sign the appropriate documents in his own behalf. In the instance that a patient suffers an adverse cardiopulmonary event related to the procedure or administration of anesthetic agent, all attempts to bring the patient back to their pre-operative state will be undertaken.

PATIENT WITH AN ADVANCE DIRECTIVE UPON ADMISSION

- Patient can provide documents: A copy should be dated and signed by the patient and placed on the patient's medical record and the original returned to the patient. The presence of an Advance Directive should be noted on the "Advance Directive Acknowledgment" form.

- Patient cannot or chooses not to provide documents: The patient may complete a new Advance Directive or as an alternative, may discuss the substance and intent of the directive with their physician.

PATIENT WITHOUT AN ADVANCE DIRECTIVE ON ADMISSION

- If the patient does not have an Advance Directive and does not express a desire to have one, this should be documented on the Conditions of Admission or Consent for Outpatient Services Forms.

- If the patient does not have an Advance Directive and wishes to have information, the admitting clerk will provide the “Georgia Advance Directive Form for Healthcare.”

- If the patient requests additional information, the admitting clerk should contact Case Management (ext. 4104) who will provide assistance to the patient once they are in their room.

EXECUTING AN ADVANCE DIRECTIVE AFTER ADMISSION

Should the patient desire to execute an Advance Directive during admission and asks for information or forms, the Case Manager or Nursing Supervisor will be contacted.

A. The patient will be provided a “Georgia Advance Directive Form for Healthcare.”

B. The Case Manager or Nursing Supervisor may clarify the definition and purpose of Advance Directives if requested by the patient.

C. It is the patient's responsibility to complete the Advance Directive including signatures and witnesses. Hospital employees may not serve as witnesses.
D. The complete directive should be returned to the Nurse who will review it for completeness. A copy will be made and placed on the medical record and the original will be returned to the patient. The nurse will notify the physician that an Advance Directive has been executed by the patient.

E. Any oral Advance Directives made by the patient should be documented in the progress notes and the physician should be immediately notified.

F. Hospital employees may not suggest that a patient fill out an Advance Directive, nor may they provide advice as to its completion or suggest agencies or individuals to provide assistance.

AMENDMENT OF AN EXISTING ADVANCE DIRECTIVE
A patient may amend or revoke a previously executed Directive at any time. The patient's nurse should be notified of any oral or written requests to amend an existing Advance Directive.

Revoking a Previous Directive
- Strike a large "x" through the Directive as it appears on the Medical Record.
- If the patient is able, the patient should note on the document that it is his desire to revoke this directive. The nurse may also write the word "Revoked" across the page.
- The patient should sign and date this change. The revoked "Advance Directive” should remain on the medical record.
- The nurse will notify the Physician of the Change in Directive.

Amending a Previous Directive
- The hospital staff member who is aware of the patient's desire to revoke an Advance Directive will notify the patient's nurse.
- If the patient requests additional information or forms, the nurse will contact the Case Manager or in her absence, the Nursing Supervisor who will provide such.
- The nurse will review the amended Directive and perform the following:
  - If necessary, revoke the previous Directive.
  - Review the Directive for completeness and make a copy to be placed on the patient's medical record in front of the old Directive.
  - The nurse will notify the physician of the change in Directive.

MAINTENANCE OF THE ADVANCE DIRECTIVE
- A copy of the Advance Directive will be made for the patient's medical record. This copy will be dated and authenticated for the current admission.
- The original advance directive will be returned to the patient.
The advance directive copy will always remain in the same record, not to be "thinned out" if the record should become voluminous.

**Patient Transfer:**
- **Temporary** - If the patient leaves the facility (such as transfer for treatment or diagnostic procedure at another facility), a copy of the advance directive will be sent with the patient.
- **Permanent** - If a patient is transferred to another health care facility (such as a hospital or nursing home), a copy of the advance directive will be sent to the receiving facility with the patient.

Each time a patient is admitted, the advance directive copy will be dated and signed by the patient in order to validate its currency.

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**Ethics & Compliance Program**

**Coliseum Health System**
- Coliseum Medical Centers
- Coliseum Psychiatric Center
- Macon Northside Hospital

**ETHICS AND COMPLIANCE PROGRAM**

**SCOPE OF SERVICE**

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**Mission and Values and the Ethics and Compliance Program**

The HCA Mission and Values Statement is as follows:

*Above all else, we are committed to the care and improvement of human life. In recognition of this commitment, we will strive to deliver high quality, cost-effective healthcare in the communities we serve. In pursuit of our mission, we believe the following value statements are essential and timeless:*

- We recognize and affirm the unique and intrinsic worth of each individual.
- We treat all those we serve with compassion and kindness.
- We act with absolute honesty, integrity, and fairness in the way we conduct our business and the way we live our lives.
- We trust our colleagues as valuable members of our healthcare team and pledge to treat one another with loyalty, respect, and dignity.
Through the Ethics and Compliance Program, Coliseum Health System will create and maintain a culture that promotes the highest standards of Ethics and Compliance. Such standards are designed to ensure that the system, including all hospital facilities and colleagues, operates in a manner that complies with legal and programmatic requirements of federal, state, and private payer health care programs. Furthermore, such a culture will ensure that the system meets the obligations set forth in our mission and values statement and affirmed in our fundamental commitment to stakeholders.

**Purpose**

Coliseum Health System is committed to a comprehensive Ethics and Compliance Program that is guided by the HCA Code of Conduct. The Code, which was developed to ensure that hospital facilities meet ethical standards and comply with applicable laws and regulations, defines our obligations related to patients, affiliated physicians, third-party payers, subcontractors, independent contractors, vendors, consultants, and one another.

**Scope of Service and Objectives**

Adherence to the Code of Conduct and our fundamental commitment to stakeholders is a responsibility of all colleagues of Coliseum Health System. Consequently, the Ethics and Compliance Program is applicable to all departments, services and health care professionals of Coliseum Health System, including Coliseum Medical Centers, Coliseum Behavioral Health Center, and Macon Northside Hospital.

The objectives of the Ethics and Compliance Program are as follows:

- To establish a culture within the health system that promotes prevention, detection, and resolution of instances of conduct that do not conform to federal and state law, and federal, state and private payer health care program requirements.

- To effectively articulate and demonstrate the organization’s commitment to the compliance process.

- To establish benchmarks that demonstrate implementation and achievements.

- To provide guidance to all colleagues on ethical and legal standards.

- To provide guidance to the governing body, CEOs, managers, employees, physicians and other health care professionals on the efficient management and operation of the health system.

- To provide a central coordinating mechanism for furnishing and disseminating information and guidance on applicable federal and state statutes, regulations, and other requirements.

- To identify areas of weakness/noncompliance in internal systems and management.

- To create a centralized source for distributing information on health care statutes, regulations, and other program directives related to fraud, abuse, and related issues.

- To develop a methodology that encourages employees to report potential problems and concerns.

- To develop mechanisms for early detection and reporting of violations or concerns in order to minimize governmental loss from false claims; thereby reducing the health system’s exposure to civil damages and penalties, criminal sanctions, and administrative remedies, such as program exclusion.

- To effectively communicate the requirements, standards, and procedures for ethics and compliance training and education.
To enforce standards through well publicized disciplinary guidelines.

To respond to detected offenses and develop corrective action initiatives.

To audit and monitor compliance.

To enhance the quality of care provided.

To comply with applicable laws, regulations, and standards.

To implement and maintain professional standards of conduct and moral judgment.
AGE-RELATED RISK HAZARDS

NEONATAL (Age 0 – 1 Year)

1. A parent or responsible adult should remain with a child that requires supervision and does not have independent safety skills.
2. Infants should be placed in a crib when appropriate accept when an adult is at the bedside and directly facing the infant.
3. Light plastic wrappings are never permitted on sheets and pillows
5. Encourage parents to require identification from anyone entering the room.
6. Cords and tubing should be secured to prevent strangulation
7. When a small child has finished eating, his feeding equipment should be removed and he should be returned to his crib immediately.
8. Toys should be suitable for the age and condition of the child.
9. Children should not be given any toys made of glass or having sharp edges, flaking paint or parts that can be detached and swallowed.
10. Toys should never be left in the cribs of sleeping children; they should be stored in proper storage areas and never left on the floor.
11. Use oral routes for medication administration
12. Heightened vigilance about monitoring infants for adverse drug reactions including allergy. Infants can have very sensitive responses to small amounts of medication.
13. No cleaning supplies are to be left in a pediatric patient room or left unattended by Environmental Services.
**PEDIATRIC PATIENTS (1 – 12 Years)**

1. A parent or responsible adult should remain with a child that requires supervision and does not have independent safety skills.
2. Infants should be placed in a crib when appropriate except when an adult is at the bedside and directly facing the infant.
3. Side rails should remain up on all beds used for pediatric patients. Beds should remain in the lowest position. Electric beds must have child protection feature.
4. Pillows may not be used in cribs. If used for older children, they should be firm and offer support.
5. Light plastic wrappings are never permitted on sheets and pillows.
7. Use oral routes for medication administration as often as possible when appropriate.
9. Respond promptly to meet the child’s needs.
10. Encourage parents to require identification from anyone entering the room.
11. Cords and tubing should be secured to prevent strangulation.
12. When a small child has finished eating, his feeding equipment should be removed and he should be returned to his crib immediately.
13. Toys should be suitable for the age and condition of the child.
14. Children should not be given any toys made of glass or having sharp edges, flaking paint or parts that can be detached and swallowed.
15. Heightened vigilance about monitoring infants for adverse drug reactions including allergy. Infants can have very sensitive responses to small amounts of medication.
17. Toys should never be left in the cribs of sleeping children; they should be stored in proper storage areas and never left on the floor.
18. No cleaning supplies are to be left in a pediatric patient room or left unattended by Environmental Services.
ADOLESCENT PATIENTS (13 – 18 Years)

1. Reassure and support a positive self-image
2. Offer education and training within their capacity. It may be necessary to educate parents at a different location to support adolescent responsibility.
3. Provide counseling on the dangers of physical injury and general safety
5. Respect privacy and confidentiality
6. Avoid conflicts in authority. Create an environment where the adolescent is willing to listen to instruction and cooperate with healthcare workers.
7. Watch for signs of depression or suicidal considerations.
ADULT PATIENTS (19 – 65 Years)

1. Adults, like all age levels should be assessed for their level of knowledge and capacity to understand their diagnosis and treatment. Physical stature and incapacity may warrant consideration of additional safety measures;
2. Bedside rails should remain up for patients with altered level of consciousness. These patients shall be observed closely when sitting in chairs or wheel chairs.
3. Rooms and halls should be kept clear of furniture or equipment
4. Floors are to be kept clean and dry and clear of towels or obstructions.
5. Adult patients may not acknowledge restrictions their current health condition places on their mobility. Emphasize the importance of obtaining assistance when going to the bathroom or ambulating.
6. Patients should be instructed in safety measures to prevent falls.
7. Patients should be questioned frequently for needs, especially bathroom privileges. Bedside commodes should be utilized when warranted.
8. Provide education about the disease processes and medication. Warn patients of the dangers of non-compliance and self-medication.
9. The patient's glasses should be stored within reach when not being worn.
GERIATRIC PATIENTS (Over 65 Years)

1. Bedside rails should remain up for patients with altered level of consciousness. These patients shall be observed closely when sitting in chairs or wheel chairs.
2. Offer frequent meals of the patient’s choosing to promote adequate nutritional intake.
3. Rooms and halls should be kept clear of furniture or equipment.
4. Floors are to be kept clean and dry and clear of towels or obstructions.
5. Handrails must be available in showers and baths.
6. Patients should be instructed in safety measures to prevent falls.
7. Patients should be questioned frequently for needs, especially bathroom privileges. Bedside commodes should be utilized when warranted.
8. Watch for patient hypersensitivity to medications.
9. Application of hot or cold should be monitored closely.
10. Teach patients about the use of assistive or adaptive devices.
11. The patient's glasses should be stored within reach when not being worn.
12. Notations are to be made on the call system if patient is unable to hear or speak.
13. Night lights should be left on when the room is dark.
DISABILITY SERVICES

PURPOSE: To ensure to the greatest attempt possible that deaf/hearing-impaired individuals have the same access to the services of Coliseum Medical Centers. This includes auxiliary aids and services necessary for effective communication.

REGULATIONS:
Accommodation of deaf/hearing impaired individuals is addressed in the following regulations

Rehabilitation Act of 1973 (Section 504)

Americans with Disabilities Act
Title II – Not applicable (applies to hospitals run by a public Hospital Authority).
Title III – Enhance effective communication so that the individual may have “full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation”

Application: Application of the ADA has been expanded to include accommodation of the patient as well as any individual with significant involvement in the care and decision-making for the patient. For example, an interpreter must be provided for a deaf parent of a child who is a patient.

VISUAL

A. Documentation: Indicate on the Care Plan and chart that the patient is visually impaired.

B. Orientation

1. All individuals entering the patient’s room should introduce himself.

2. Any written material/instructions should be read aloud as many times as the patient needs for understanding.

3. Care should be taken not to disturb the location of objects in the patient’s room.

4. Notify the patient of new objects or items placed in the room.

Resources: Braille publications are available from the Public Library.
5. Indicate the disability on the Care Plan.
6. Indicate on the intercom that the patient is deaf/mute and that patient signal will have to be answered in person.
7. Provide a paper and pencil at bedside.
8. Evaluate for possible use of a Sign Language Interpreter.
9. If the patient reads lips, remember to face them when speaking and talk in a natural voice.
10. Enhanced Telephone: The hospital has several telephones with adjustable volume controls to enhance sound. They also have an indicator light which blinks to let the patient know the phone is ringing. These phones can be installed by Building Service.
11. TDD Communication: The hospital has several mobile TDD machines. Building Services will connect the TDD at a convenient location for patient/visitor use.

12. State of Georgia Relay System for the Hearing-Impaired: A system which can translate a voice message to a TDD machine which can be read by a hearing impaired individual. The opposite can also be accomplished by translating a written TDD message to a voice message.
   Voice Service: 1-800-255-0135
   TDD Service: 1-800-255-0056

C. Obtaining Deaf Interpreter Services

1. Confirm that the patient uses American Sign Language (ASL) and wants an interpreter.

2. Referencing the Policy, determine when an interpreter will be needed. It may be prudent to coordinate all services requiring the interpreter, including those provided by a physician, it is important to remember that accommodating a disability must be done with the same expectations as a non-disabled person.

3. It is the responsibility of the department providing care to arrange for an interpreter.

4. Utilize Language Services Associates as primary American Sign Language (ASL) interpreting (b and c options are listed as alternatives).
   a. Language Services Associates 1–800-305-9673
      Video Remote Interpreting Service (via Portable Computer Station located in Human Resources)
RESTRAINT USE

SCOPE:
This policy/procedure applies to healthcare professionals operating within HCA facilities that have responsibility for ordering, assessing, care planning, restraining, or monitoring the restrained patient. This policy is applicable to all age groups of patients, including neonates.

PURPOSE:
1. To protect the dignity and safety of inpatients, outpatients, staff and visitors through safe restraint processes.¹
2. To identify patients at risk for restraint and provide alternatives to restraint use.
3. To provide guidelines for use of least restrictive interventions to avoid restraint use. To define the procedure to be followed when all alternatives have been exhausted and proven ineffective, and restraints are necessary to maintain patient safety.
4. To define staff training requirements related to safe restraint processes. Refer to Appendix A for training requirements.

POLICY:
HCA is dedicated to fostering a culture that supports a patient’s right to be free from restraint or seclusion. Restraint use will be limited to clinically justified situations, and the least restrictive restraint will be used with the goal of reducing, and ultimately eliminating, the use of restraints. The facility Chief Nursing Officer (CNO) provides leadership and organizational accountability for monitoring the safety, appropriateness and necessity of restraint use.

PROCEDURE:
1. Assessment for Risk for Restraint
   a. The Registered Nurse (RN) performs an assessment for risk for restraint when a patient exhibits behavior that may place the patient at risk for restraint. This risk assessment includes:ii
      1) Does the patient have a medical device?
      2) Does the patient understand the need to not remove the device?
      3) Is the patient required to be immobile?
      4) Does the patient understand the need to remain immobile?
      5) Is the patient exhibiting aggressive, combative or destructive behavior?
      6) Does this behavior place the patient/staff/others in immediate danger?

   b. The assessment for the risk for restraint also includes:
      1) Patients who arrive in restraint.
      2) Patients in restraint who have recovered from the effects of anesthesia and are awaiting transfer to a bed.
      
      Note: Patients in the NICU and nursery are excluded from the assessment for risk for restraint.

2. Alternatives to Restraint
   Patients that are determined to be at risk for restraint will have alternatives initiated promptly. Appendix B contains a listing of alternatives to restraint.
3. Determination That Alternatives to Restraint Have Failed
   The RN determines that alternatives to restraint have failed and that the patient will be safer in restraints than continuing without restraint.

4. Second Tier of Review
   A member of nursing administration/management (e.g., nursing supervisor, manager/director, CNO, etc.) will review the need for restraint with the RN who has determined that the patient requires restraint. The review includes:
   a. Alternatives attempted
   b. Reason for restraint
   c. Least restrictive type of restraint
   d. Staff’s knowledge of the cause of patient behavior (physiological, psychological, environmental, medication)
   e. Appropriate restraint for vulnerable patient populations
   f. Staffing available for monitoring
   g. Affirmation of partnering to meet the patient needs with safety and compassion
   Note: In an emergency application of the restraint, the above review will be done immediately after the application of restraint.

5. Order for Restraint
   a. An order for restraint must be obtained from an LIP/physician who is responsible for the care of the patient prior to the application of restraint. The order must specify clinical justification for the restraint, the date and time ordered, the duration of use, the type of restraint to be used and behavior-based criteria for release.
      1) An order for restraint may not be written as a standing order, protocol or as a PRN or “as needed” order.
      2) If a patient was recently released from restraint or seclusion, and exhibits behavior that can only be handled through the reapplication of restraint or seclusion, a new order is required.
   b. If a telephone order is required, the RN must write down the order while the physician is on the phone and read-back the order to verify accuracy. The order must specify clinical justification for the restraint, the date and time ordered, the duration of use, the type of restraint and behavior-based criteria for release.
   c. The treating physician is to be notified as soon as possible if another physician, (e.g., on-call physician) orders the restraint.
   d. When a LIP/physician is not available to issue a restraint order, an RN with demonstrated competence may initiate restraint use based upon face-to-face assessment of the patient. In these emergency situations, the order must be obtained during the emergency application or immediately (within minutes) after the restraint is applied.

5A. Order for Restraint with Non-Violent or Non-Self Destructive Behavior
   a. Duration of order for restraint must not exceed twenty-four (24) hours and must specify clinical justification for the restraint, the date and time ordered, the duration of use, the type of restraint and behavior-based criteria for release.
      1) Twenty-four (24) hours is the maximum duration. The physician may order a shorter period of time.
2) Staff assess, monitor, and re-evaluate the patient regularly and release the patient from restraint when criteria for release are met.

b. To continue restraint use beyond the initial order duration, the LIP/physician must see the patient, perform a clinical assessment and determine if continuation of restraint is necessary.

c. If reassessment indicates an ongoing need for restraint, a new order must be written each calendar day by the LIP/physician.

5B. Order for Restraint with Violent or Self Destructive Behavior

a. Physician orders for restraint must be time limited, and must specify clinical justification for the restraint/seclusion, the date and time ordered, duration of restraint/seclusion use, the type of restraint, and behavior-based criteria for release. Orders for restraint or seclusion must not exceed:

   1) 4 hours for adults, aged 18 years and older
   2) 2 hours for children and adolescents aged 9 to 17 years, or
   3) 1 hour for children under 9 years

   i. The time frames specified are maximums. The physician may order a shorter period of time.

   ii. Staff assess, monitor, and re-evaluate the patient regularly and release the patient from restraint or seclusion when criteria for release are met.

b. To continue restraint or seclusion beyond the initial order duration, the RN determines that the patient is not ready for release and calls the ordering physician to obtain a renewal order. Renewal orders for restraint/seclusion may not exceed:

   1) 4 hours for adults, aged 18 years or older
   2) 2 hours for children and adolescents aged 9 to 17 years, or
   3) 1 hour for children under 9 years

c. Orders may be renewed according to time limits above for a maximum of 24 consecutive hours. Every 24 hours, unless state law is more restrictive, a physician or other authorized LIP primarily responsible for the patient’s care sees and evaluates the patient before writing a new order for restraint or seclusion.

6. Application of Restraints

a. Restraints are applied by staff with demonstrated competence in restraint application.

b. The patient is informed of the purpose of the restraint and the criteria for restraint removal.

c. The patient’s family is informed of restraint use, the purpose of the restraint and the criteria for removal.

7. Monitoring the Patient in Restraints

a. Patients are assessed by an RN immediately after restraints are applied to assure safe application of the restraint.

b. An RN will assess the patient at least every 2 hours. The assessment will include:

   1) Signs of injury associated with restraint, including circulation of affected extremities
   2) Respiratory and cardiac status
   3) Psychological status including level of distress or agitation, mental status and cognitive functioning
   4) Needs for range of motion, exercise of limbs and systematic release of restrained limbs are being met
   5) Hydration/nutritional needs are being met
6) Hygiene, toileting/elimination needs are being met
7) The patient’s rights, dignity, and safety are maintained
8) Patient’s understanding of reasons for restraint and criteria for release from restraint
9) Consideration of less restrictive alternatives to restraint
c. More frequent monitoring and notification of the ordering physician or LIP occurs when:
   1) Patient’s medical and emotional needs and health status change
   2) The type and design of the device or intervention poses increased risk
   3) The level of patient agitation/distress at being placed in restraint as evidenced by an escalation of behavior
   4) Evidence of injury related to use of restraint
d. A trained staff member monitors each patient in restraint at least 3 times an hour for safety, and to confirm that the patient’s rights and dignity are maintained. This check will be documented in either electronic record or on paper and may be recorded at the end of the shift.
e. Monitoring is based on the individual needs of the patient. Variables of the patient’s condition, cognitive status, risks associated with the chosen intervention may require more frequent evaluations.
f. For patients under continuous audio, video or in-person observation, care is rendered in real time, but documentation that safety, rights, and dignity were maintained for the defined period of time may be entered at end of the shift.
g. Any change in physical or psychological response will be reported to the RN. The RN will determine if medical intervention is required or if criteria for release have been met.

8. Simultaneous Use of Restraint and Seclusion
   A patient in restraint and seclusion simultaneously requires a higher level of monitoring:ix
   a. Continuous, uninterrupted monitoring, face-to-face by a specifically assigned staff member with demonstrated competence in close proximity to the patient for at least the first hour.
b. After the first hour, continuous uninterrupted monitoring, by a specifically assigned staff member with demonstrated competence using both video and audio equipment, with monitoring done in close proximity to the patient so as to allow emergency intervention if a problem arises. The use of video and audio equipment does not eliminate the need for frequent monitoring and assessment of the patient.

9. Face-to-face assessment by a Physician or LIP:
   a. A face-to-face assessment by a physician or LIP, RN or physician assistant with demonstrated competence, must be done within one hour of restraint/seclusion initiation or administration of medication to manage violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others. At the time of the face-to-face assessment, the LIP/physician/RN/PA will:x
      1) Work with staff and patient to identify ways to help the patient regain control
      2) Evaluate the patient’s immediate situation
      3) Evaluate the patient’s reaction to the intervention
      4) Evaluate the patient’s medical and behavioral condition
      5) Evaluate the need to continue or terminate the restraint or seclusion
      6) Revise the plan of care, treatment and services as needed

Note: A telephone call or telemedicine methodology does not constitute face-to-face assessment.
b. When the 1-hour face-to-face is performed by a RN or physician assistant with demonstrated competence, the following must occur:
   1) The RN or physician assistant with demonstrated competence must consult the attending physician or LIP who is responsible for the care of the patient as soon as possible after the completion of the 1-hour face-to-face evaluation. (“As soon as possible” is to be as soon as the attending physician is able to be reached by phone or in-person.) A consultation that is not conducted prior to renewal of the order would not be consistent with the requirement “as soon as possible.”xi
   2) The consultation should include, at a minimum, a discussion of the findings of the 1-hour face-to-face evaluation, the need for other treatments, and the need to continue or discontinue the use of restraint or seclusion.
   3) If a patient who is restrained or secluded for aggressiveness or violence quickly recovers and is released before the physician arrives to perform the face-to-face assessment, the physician must still see the patient face-to-face to perform the assessment within 24 hours after the initiation of restraint/seclusion.

10. Care of the Patient/Plan of Care:xii
   a. The plan of care will clearly reflect a loop of assessment, intervention, and evaluation for restraint, seclusion and medications.
   b. Patients and/or families should be involved in care planning to the extent possible and made aware of changes to the plan of care.

11. Discontinuation of Restraint/Seclusion:
   a. The patient in restraint/seclusion is evaluated frequently and the intervention is ended at the earliest possible time. The time-limited order does not require that the application be continued for the entire period.
   b. When an RN determines that the patient meets the criteria for release in the restraint order, restraints are discontinued by staff with demonstrated competence.
   c. Once restraints are discontinued, a new order for restraint is required to reapply restraints.
   d. A temporary release that occurs during patient care, e.g. toileting, feeding or range of motion, is not considered a discontinuation of restraint/seclusion.

12. Documentation Requirements:
   The medical record contains documentation of:
   a. Assessment for risk for restraint
   b. Restraint alternatives employed
   c. Determination of effectiveness/ineffectiveness of restraint alternatives
   d. Second tier review of need for restraint
   e. Order for restraint and any renewal orders for restraint
   f. Restraint application
   g. Family notification of restraint use
   h. Patient and family education regarding restraint use
   i. Assessment of the patient in restraint/seclusion
   j. Monitoring of the patient in restraint/seclusion
   k. Medical and behavioral evaluation for restraint management of violent or self-destructive behavior
l. Modifications of the plan of care  
m. Physician notification of changes in patient condition  
n. Restraint removal  

13. Performance Improvement:  
   a. Data on the use of restraint and seclusion is collected to monitor appropriate use and to identify process improvement opportunities.  
   b. Data elements include:  
      1) Number of patients restrained  
      2) Number of restraint hours  
      3) Type of restraints  
      4) Number of restraint episodes  
      5) Number of patient injuries/deaths while restrained  
   c. Data is trended, patterns of use, safety, and effectiveness are evaluated. Progress toward preventing, reducing and eliminating the use of restraints is assessed.  
   d. Results of analysis are shared with facility leadership and appropriate committees, the Medical Executive Committee and the Board of Trustees.  
   e. If any inappropriate use of restraints is identified, a root cause analysis will be performed, measures identified and implemented to remedy the issue(s).  
   f. Any death which occurs within 24 hours of a patient being in a restraint must be reported in compliance with CMS and state guidelines. In addition, any death that occurs within a week after the restraint was used and it is reasonable to assume that the restraint contributed directly or indirectly to the death is reported.  

(See Appendix C)
APPENDIX B: ALTERNATIVES TO RESTRAINT

A. Psychosocial Alternatives
   Diversion
   Family interaction
   Orientation
   Pastoral visit
   Reassurance
   Reading
   Relaxation techniques
   Interpreter services
   Personal possessions available
   Quiet area
   One-on-one discussion
   Decreased stimulation
   Change in environment
   Re-establishing communication
   Setting limits

B. Environmental Alternatives
   Commode at bedside
   Decreased noise
   Music/TV
   Night light
   Room close to nursing station
   Call light within reach
   Bed alarm in use
   Specialty low bed
   Sensory aids available (glasses, hearing aid)
   Decreased stimulation
   Providing a quiet area
   Physical activity
   Orientation
MATERIAL SAFETY DATA SHEETS

DEFINITION
Material Safety Data Sheets are produced by the manufacturer to provide the following information to the users of their product.

MSDS INFORMATION
- Name of the Product
- Ingredients (Scientific name) and percent representation in the product.
- Handling and storage
- Identification of product risks (Carcinogenic, vapor risk, flammable) Precautions to be taken by users
- Treatment for accidental exposure to the product

DEPARTMENT MSDS MANUALS
Each Department is responsible for maintaining a hard copy departmental specific MSDS manual that contains MSDS's pertinent to the individual department.
Each Department may also access the Coliseum Medical Centers complete electronic MSDS manual by going to Insight, Facilities, Coliseum Medicals Centers, and Electronic Material Safety Data Sheets.

MASTER INDEX
There is a master index of all MSDS used in the hospital. These are located in Building Services and Emergency Services and on the CMC Intranet site.
EMERGENCY CODES/FIRE SAFETY

CODE BLUE   Cardiac Arrest - Adult
CODE BLUE PALSCardiac Arrest - Child
CODE RED    Fire  (Remember:  RACE)
CODE GREY   Security/Combative Situation/Person
CODE ORANGE Hazardous Materials Spill
CODE TRIAGE Disaster Plan Activation; Mass Casualty Disaster
CODE PINK   Infant/Child Abduction
CODE SILVER Hostage Situation/Person with a Weapon
CODE B      Bomb Threat
WEATHER CODE Weather Alert/Watch/Warning
CODE GREEN  Decon Team Activation
CODE E      Emergency Situation/Accident
CODE S      Signs of Stroke
SEPSIS ALERT Signs of Septic Shock
RAPID RESPONSE Early and Rapid Intervention Needed
CODE STEMI  STEMI Alert

TO REPORT AN EMERGENCY CODE DIAL 4222

FIRE RESPONSE

R………………………………………..RESCUE
A………………………………………..ALARM
C………………………………………..CONTAIN/CONFINE
E………………………………………..EXTINGUISH/EVACUATE

FIRE Extinguisher OPERATION

P………………………………………..PULL THE PIN
A………………………………………..AIM AT BASE OF FIRE
S………………………………………..SQUEEZE THE TRIGGER
S………………………………………..Sweep back and forth
Security Tips

The safety and security of students while on campus is of the utmost importance. Students should engage in activities that promote personal safety and security:

- Do not bring pocketbooks or other valuable to the clinical area as space to securely store may not be available.
- Lock any valuable and personal items in the trunk prior to arriving at the hospital. This includes pocketbooks, CD’s, cell phones, etc that might be visible in your vehicle.
- Only carry minimal cash on your person.
- Leave jewelry at home.
- Always be aware of your surroundings and alert for any suspicious activities or individuals.
- Park only in assigned/designated areas.
- When entering or leaving the hospital in the early morning or late evening when it is dark: Park in well-lit areas
- Use a buddy system or call security, do not walk in and out alone.
- Have your keys ready to unlock your car.


CMC Parking Map

Blue Zones: Employee Parking

Employees are prohibited from parking in any other zone other than those designated above.
SMOKING POLICY

PURPOSE
In an effort to reduce the risks of smoking, including possible adverse effects on treatment, reduce risks of passive smoking for others, and reduce the risk of fire, Coliseum Medical Centers prohibits smoking by patients, visitors, and staff throughout the hospital. All exceptions to the “No Smoking” policy for patients must be authorized by the patient’s physician and based on criteria defined by the medical staff. There are no exceptions to the policy for visitors or staff.

APPLICATION

Patients
When sudden withdrawal potentially interferes with the patient’s treatment plan, the physician may write an order allowing the patient to smoke in an outside area designated for smoking. Smoking cessation education and instruction is available to patients. Nicotine replacement therapy may be implemented with a physician’s order. The following patient populations are prohibited (no medical exceptions) from smoking:

- All child and adolescent patients
- All hospital-based ambulatory care patients

Patients that refuse to abide by CMC smoking policies may suffer the consequences of non-treatment.

Visitors
Visitors are permitted to smoke in outside areas designated for smoking where cigarette disposal containers have been provided. There will be no smoking within 25 ft of building. Visitors are not permitted to smoke anywhere inside the building. An employee should seek the assistance of a supervisor when dealing with a visitor who is observed smoking in an “undesignated area.”

DESIGNATED SMOKING AREAS

The following outdoor areas are designated for smoking:
A. Main Hospital – Behind Dietary in Smoking Shelter
B. Building C – Behind building in designated area
CONFIDENTIALITY

Quality medical care is related to the patient’s freedom to disclose detailed personal information and the healthcare professionals pledge to protect it. All patient information is considered confidential and may be released only to individuals designated by the patient or healthcare providers on a need to know basis. Patient information should not be released or discussed unless it is necessary to serve the patient or required by law. You should never disclose confidential patient information that violates the privacy rights of our patients. Patient information will only be released to persons authorized by law or by the patient’s written consent.

STEPS TO ASSURE PRIVACY/CONFIDENTIALITY

A. All interviews with the patient/family should be conducted in an area without threat of being overheard. Usually, closing a door will accomplish this.

B. Consultation or discussion involving the patient will be conducted discreetly.

C. Only individuals designated by the patient will be allowed to participate in decision-making processes.

D. The medical record should be assessable and read only by individuals directly involved in their treatment or in the handling of records.

E. All information pertaining to payment are confidential.

NO PRESS - NO INFO

A. Patients may request a "No Press - No Info" status for admission. No information related to the patient may be released including name, confirmation of hospitalization, or condition.

B. All Psychiatric patients are considered "No Press - No Info".
INFECTION CONTROL

STANDARD PRECAUTIONS

Standard Precautions combine the major features of Universal Blood and Body Fluid Precautions (designed to reduce the risk of transmission of bloodborne pathogens) and Body Substance Isolation (designed to reduce the risk of transmission of pathogens from moist body substances) and applies them to all patients receiving care in the hospital regardless of their diagnosis or presumed infection status.

STANDARD PRECAUTIONS APPLY TO:

- All Body Fluids and Secretions except sweat (regardless of whether or not they contain visible blood)
- Non-intact skin
- Mucous Membranes

Standard Precautions are designed to reduce the risk of transmission of microorganisms from both recognized and unrecognized sources of infection in the hospital by use of the following fundamental infection control measures.

FUNDAMENTALS OF STANDARD PRECAUTIONS

Handwashing and Hand asepsis:
Handwashing is recognized as the single most effective infection control practice known to reduce the risk of transmission of infectious agents. Handwashing is to be performed frequently and is mandatory before and after contact with each patient. Handwashing should be performed as part of each employee’s routine hygiene practice regardless of job category. Hands must be washed with soap and water whenever visibly soiled. Alcohol-based hand rubs are provided in addition to soap and water for hand sanitation. Hands should be washed and/or sanitized at a minimum, upon presentation for work, after restroom usage, before and after eating, and prior to leaving the work environment. Additionally, employees are required to wash or sanitize their hands whenever they have contact with an obviously unclean surface or whenever the hands have become contaminated from the environment. Employees with patient contact are required to wash and/or sanitize their hands before and after each patient contact and after removing gloves. Good handwashing & hand antisepsis practices benefit the employee as well as our patients. Alcohol-based hand sanitizers are available in addition, but not as a replacement for, soap and water handwashing.

Gloves: **Gloves are worn for 3 important reasons in the hospital:**
To provide a protective barrier and to prevent gross contamination of the hands when touching blood, body fluids, secretions, excretions, mucous membranes, and non-intact skin.
To reduce the likelihood that microorganisms present on the hands of personnel will be transmitted to patients, and to reduce the likelihood that hands of personnel contaminated with microorganisms from a patient or a fomite, transmit these microorganisms to another patient.
Gloves are required when working with patients. Gloves should be donned at bedside and removed at bedside. They should be worn when handling patient items or when attending the environment if contamination is
expected. Gloves provide protection from patient contact and also reduce the transfer of organism between employee and patient through absent-minded touching. Gloves are never a substitution for handwashing. Because organisms multiply quickly under gloves and may be introduced through small tears in the glove, hands must be thoroughly washed when gloves are removed. Gloves should never be worn outside of a patient’s room and should never be reused for any purpose.

Gowns/Protective Apparel:
Various types of gowns and protective apparel are worn to provide barrier protection by preventing contamination of clothing and to protect the skin of personnel from blood/body fluid exposure. Gowns/aprons treated to make them impermeable to liquids provide greater protection to the skin when splashes or large quantities of infective material are present or anticipated. Gowns are worn by personnel during the care of patients infected with drug resistant microorganisms to reduce the opportunity for transmission of pathogens from patients or items in their environment to other patients or environments. When gowns are worn for this purpose, they are removed before leaving the patient’s environment. Even protective apparel which becomes contaminated is not an infectious risk itself. It is not until the microorganisms are picked up on the hands and transferred to other areas of the body or another patient that transmission occurs. For this reason, gloves should be worn outside of the gown sleeve and removed prior to exiting the patient’s room. Additionally, hands must be washed after glove removal.

Mask/Goggles:
Often masks and goggles are worn together. Appropriate usage is dictated by the type of isolation precautions utilized from patient to patient. Masks should be discarded after each day’s use. Masks are not to be worn around the neck or into the hallways. Goggles may be reused and may be washed with soap and water after usage. Prescription eyeglasses do not take the place of goggles. Goggles should be utilized for all personnel in situations where aerosolizing or splashing is anticipated.

Sharps Disposal:
Accidental needlesticks carry the highest risk of disease transmission in the hospital. When handling needles or other sharp instruments, care should be taken to perform slowly and deliberately. Safe Medical Devices must be activated at the point of usage. Hastily handled sharps are often the cause of injury – all sharps (safety or traditional sharps) should be placed in proper disposals immediately after usage. All needles and sharps must be placed in puncture resistant containers - this applies to all contaminated needles. This must be labeled at the time it is used for such. The box should be sealed & removed for disposal before it is too full to allow needles to fall unobstructed into the box (75% full). Sharps disposal systems are available in all patient care areas and all patient rooms. They are placed in a location which allows immediate disposal of sharps following usage. There should be no manipulation of any needle including bending, breaking, or clipping. Safety devices with hinged sharps covers or sheaths are to be used whenever possible. The cover must be put in place at the point of usage and then disposed of into the nearest sharps disposal. If safety devices are not available and a traditional needle is required, it is the policy of this hospital to practice “NO RECAPPING” of needles prior to disposal.
HAND HYGIENE

PURPOSE: Hand washing/hygiene is to reduce or prevent the transfer of microorganisms by direct or indirect spread to patients and personnel in health-care settings. Hand hygiene is the single most important activity for preventing the spread of infection. It is known that improved hand hygiene can result in the decrease of patient’s severity of illness and death from nosocomial (facility-acquired) infections.

A. Indications for Handwashing and Hand Antisepsis
   1. When hands are visibly dirty or contaminated with protein type material or are visibly soiled with blood or other body fluids/organic material, Wash hands with soap and water.
   2. If hands are not visibly soiled, an alcohol-based hand rub may be used to routinely decontaminate hands in all clinical situations. If alcohol based hand rub product is unavailable, wash hands with antimicrobial soap and water. This includes all indicators for number 3 – 10 that follow.
   3. Decontaminate hands before having direct contact with patients.
   4. Decontaminate hands prior to donning sterile gloves when inserting IVs and/or indwelling intravascular devices.
   5. Decontaminate hands before inserting indwelling urinary catheters, peripheral vascular catheters, or other invasive devices that do not require a surgical procedure, prior to donning of gloves and PPE.
   6. Decontaminate hands after contact with a patient’s intact skin (e.g., when taking a pulse or blood pressure, lifting a patient, etc.)
   7. Decontaminate hands after contact with body fluids or excretions, mucous membranes, non-intact skin, & wound dressings if hands are not visibly soiled.
   8. Decontaminate hands if moving from a contaminated body site to clean body site during patient care.
   9. Decontaminate hands after contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient.
  10. Decontaminate hands after removing gloves.
  11. Before eating and after using a restroom, wash hands with a non-antimicrobial or an antimicrobial soap and water.
  12. Wash hands with non-antimicrobial or an antimicrobial soap and water if exposure to Anthrax spores is suspected or proven. The physical action of washing and rinsing hands under such circumstances is recommended because alcohols, chlorhexidine, iodophors, and other common antiseptic agents have poor activity against spores.
  13. The routine use of non-alcohol-based hand rubs for hand hygiene in healthcare settings is
currently not recommended.

B. Hand Hygiene Technique
1. When decontaminating hands with alcohol-based hand rub, apply a dime size portion of the product to palm of one hand and rub hands together covering all surfaces of hands and fingers. Rub until hands are dry.
2. When washing hands with soap and water, wet hands first with water, apply a quarter size amount of product to hands, and rub hands together vigorously for at least 15 seconds. Cover all surfaces of the hands and fingers including wrist areas. Rinse hands with water and dry thoroughly with a disposable towel. Use towel to turn off faucet. Avoid using extremely hot or cold water as repeated exposure to extreme temperatures may increase the risk of dermatitis.
3. Liquid, bar or powdered forms of plain soap are acceptable when washing hands with non-antimicrobial soap and water. If bar soap is used, a setup that facilitates drainage should be used or the bar should be discarded after use.
4. Multiple use or roll type cloth towels are not to be used in the facility.

C. Surgical Hand Antisepsis
1. Please see Operating Room Specific Policies

D. Other Aspects of Hand Hygiene
1. Artificial fingernails, extenders, wraps, tips, etc. are not to be worn by direct caregivers, support staff, or front-line disaster responders. This aspect of the hand hygiene policy includes, but is not limited to, all employees with Bloodborne Pathogen risk designated category I as set forth in the facility Exposure Control Plan.
2. Natural nail tips are to be kept less than ¼ inch from fingertip and should never impede the protective quality of glove usage.
3. Wear gloves when contact with blood, body fluids and non-intact skin is anticipated.
4. Remove gloves at bedside after single use. Do not care for more than one patient with the same pair of gloves. Do not wash gloves between uses. Gloves are protective equipment when utilized in the intended manner (single use, disposable item). Change gloves during patient care when moving from a contaminated to a clean body site.
5. Standard Precautions apply in all clinical situations. When certain epidemiologically significant diseases occur, isolation protocols may be utilized in addition to Standard Precautions.
6. Approved hand lotion that is to be used with the current hand antisepsis is provided to minimize the occurrence of irritant contact dermatitis. Do not use petroleum or mineral oil based hand lotions as they interfere with antisepsis efforts.
7. Encourage patients and families to remind healthcare providers at all levels to decontaminate their hands.
8. With any product change, the evaluation is to include the effects and possible interactions of the hand antisepsis and lotion.

E. Selection and Maintaining Hand Hygiene Agents
1. When selecting new hand hygiene products, product trails will be done and input will be solicited from employees. The feel fragrance and skin tolerance of any product will be considered. The cost of the product will not be the primary factor. The hand hygiene product chosen is to have efficacy with low irritancy potential due to the need for use of multiple times per shift. This
applies to products used for hand antisepsis in clinical areas and those used for surgical hand antisepsis.

2. When new products are considered, the manufacturers will be contacted regarding any known interactions between products used to clean hands, skin care products and the types of gloves used.

3. Before making the decision to purchase a specific product, the dispenser systems are to be evaluated for proper function and delivery of appropriate volume of product.

4. Never add soap to a partially empty container. This is “topping off” and is well documented as offering increased potential for bacterial contamination of soap.

F. Education
   1. The policy and education for hand hygiene is initiated in hospital wide orientation and continues on the departmental level.
   2. Annual educational offerings include hand hygiene.
   3. Monitoring is done at the unit/department level during patient safety surveillance rounds. Rounds are specific to adherence with recommended hand hygiene practices. Information collected on rounds is provided to department managers and healthcare workers as performance indicators.
TYPES OF ISOLATION
IN ADDITION TO STANDARD PRECAUTIONS

AIRBORNE PRECAUTIONS
1) Private Room that has: Monitored negative air pressure
   6 to 12 air changes per hour
   Discharge of air outdoors or HEPA filtration before air is recirculated
   **KEEP THE ROOM DOOR CLOSED AND THE PATIENT IN ROOM**

2) Respiratory Protection: Wear an N95 respirator mask for known or suspected AFB disease.
   Susceptible persons should not enter the room of patients with known or suspected measles (rubeola) or
   varicella (chicken pox) if immune caregivers are available. If susceptible persons must enter the room,
   wear appropriate mask.

3) Limit the movement/transport of patients from room to essential purposes only. During transport,
   **minimize the spread of droplet nuclei by placing a surgical mask on the patient, if possible.**

CONTACT PRECAUTIONS
1) Private Room: When a private room is not available, cohort with patient(s) who has
   active infection with the same microorganisms but with no other infections.

2) Wear gloves when entering room. Change gloves after contact with infective material. Remove
   gloves before leaving the patient’s room.

3) **WASH YOUR HANDS** immediately with antimicrobial agent before leaving the patient’s room. After
   glove removal and handwashing, ensure that hands do not touch potentially contaminated environmental
   surfaces or items in the patient’s room to avoid transfer of microorganism to other patients or
   environments.

4) Wear a gown if you anticipate that your clothes will have contact with the patient, environmental
   surfaces, of items in the patient’s room or if the patient has any of the following:
   * Incontinent  * Diarrhea  * Colostomy  * Ileostomy
   * Wound Drainage not contained by a dressing

5) Remove gown before leaving the patient’s environment.

6) Limit the movement/transport of patients from room to essential purposes only. During transport,
   ensure that all precautions are maintained at all times.

7) When possible, dedicate the use of noncritical patient-care equipment for each patient.
**DROPLET PRECAUTIONS**

1) **Private Room:** When a private room is not available, cohort with patient(s) who has active infection with the same microorganism but with no other infections.

2) Mask required when entering room.

3) Limit the movement/transport of patients from room to essential purposes only. During transport, **minimize the spread of droplets by placing a surgical mask on the patient, if possible.**
BEHAVIORAL HEALTH SERVICES

Coliseum Center for Behavioral Health (CCBH) is licensed for 60 beds and is comprised of two nursing units that include the Adult Services Unit with 32 beds located on the third floor and the Seniors Unit with 10 beds located on the ground floor. The patients served are (18+ adult, 65+ geriatric) Patients are admitted with a variety of psychiatric or behavioral issues, including, but not limited to the following common diagnoses:

- Major depression with suicidal ideation
- Atypical depression
- Schizo Affective Disorder
- Bipolar Disorder
- Brief Reactive Psychosis
- Schizophrenia
- Psychosis NOS
- Substance abuses requiring detoxification
- Dual Diagnoses

Goals

The goals of the treatment programs on the nursing units include crisis stabilization with 24 hour observation and supervision while providing an intensive, comprehensive and interdisciplinary treatment program for the behavioral health impaired and chemical dependent patients.

Objectives

People in acute psychiatric crisis urgently require a safe environment, a structured and supportive social milieu, and intensive psychiatric and physiological therapeutic intervention. The Program combines these elements into a unique and effective treatment program. Every aspect of unit life is intended to assist patients in achieving their optimal level of functioning.

This units’ physical design provides a safe and appropriately sensory stimulating environment for all patients and space for therapeutic and recreational activities. The Program is furnished to provide a comfortable atmosphere and to encourage interaction among patients and staff.

The treatment staff is inter-disciplinary and includes Nurses, Social Workers, Recreation/Activity Therapists and Discharge Planners working as a team under the direction of a Physician. A psychiatrist is the attending physician. Additional physicians may be consulted, as needed, for special medical needs of the patients. This treatment team provides each patient entering the Program with a comprehensive inter-disciplinary assessment and an individually tailored plan for treatment. As clinically indicated, this treatment plan may include group therapies, family therapy, appropriate medication teaching and additional educational and skill-building activities.

Qualified personnel working within a program structure, which emphasizes patient and family participation in the treatment process, provide all of these elements of care. The Program’s treatment encourages patient involvement and responsibility through participation in treatment planning and an ongoing therapeutic community. Daily involvement in therapy groups and activity meetings develops a sense of mutual inter-dependence and support that is important in the treatment of all patients on the unit. Through this coordinated effort, the Program provides the support structure and therapeutic expertise needed to help patients stabilize
their condition and achieve a more adequate level of functioning. Each patient is provided the opportunity to take risks in an environment that is healthy and conducive to change, growth and development. In this milieu, each patient is encouraged to take responsibility for their actions and beliefs and know that they will be supported by caring professionals who are focused on facilitating patient’s growth.

### 2014 NATIONAL PATIENT SAFETY GOALS

<table>
<thead>
<tr>
<th>GOAL</th>
<th>REQUIREMENT</th>
<th>CMC COMPLIANCE IMPORTANT INFORMATION YOU NEED TO KNOW</th>
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</table>
| Patient Identification    | **Use two identifiers** when administering medications or blood products, taking blood samples & other specimens for clinical testing, or providing any other treatments or procedures.  
Containers used for blood and other specimens should be labeled in the presence of the patient.  
Prior to a blood or blood component transfusion:  
Match the blood/blood component to the order.  
Match the patient to the blood/blood component.  
Use a 2 person verification process. | **KNOW:**  
Patient Identifiers at CMC:  
1. Patient Name  
2. Date of Birth  
   - You never use the room # to identify a patient  
   - When using eMAR, you must scan the patient’s armband  
   - Be able to talk about the process if the armband will not scan or the patient’s armband is missing. |
A Critical Test Result is a value or result that indicates a patient is at risk of imminent danger unless appropriate therapy is promptly initiated. All critical results are to be reported to the caregiver as soon as they are confirmed as being critical. A Critical Test is defined as being critical in nature regardless of whether the result is normal or abnormal.

KNOW:

**Critical Test Results**

- Critical test results do not just include lab values. It includes critical test results from other areas such as Radiology, Cardiology, Respiratory, etc.
- The nurse should report critical results to the physician within 15 minutes of receiving the result. If the MD does not respond within 30 minutes, the nurse should make a second call. If the MD does not respond to the second call within 15 minutes, the nursing supervisor should be notified.
<table>
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<tr>
<th>Containers (for example, syringes, medicine cups, basins), or other solutions on and off the sterile field in perioperative and other procedural settings must be labeled unless immediately administered. An authorized staff member prepares or obtains, takes directly to the patient and administers without any break in the process.</th>
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<tr>
<td>Labeling applies even if there is only 1 medication being used and should occur when any medication or solution is transferred from the original packaging to another container. Medication or solution labels include: Medication Name Strength Quality Diluent and Volume Expiration date when not used within 24 hours Expiration time when expiration occurs in less than 24 hours</td>
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<tr>
<td>Reduce health care associated infections</td>
</tr>
<tr>
<td>Hand hygiene, contact precautions, cleaning and disinfecting patient care equipment and the patient’s environment are essential strategies for preventing the spread of health care associated infections. Multi drug resistant organisms (MDROs), central line associated bloodstream infections and surgical site infections are all health care associated infections.</td>
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<tr>
<td>Know: MDROs include MRSA, c. difficle, VRE, and mult-drug resistant gram - negative bacteria. Patients who are infected or colonized with a multi-drug resistant organism and their families should be educated about health care associated infection prevention strategies. Patients and their families should be educated on central line associated bloodstream infections prior to insertion of a central</td>
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</table>
venous catheter. The nurse should complete the catheter insertion screen in Meditech and follow the standardized protocol for central venous catheter insertion, maintenance and removal. For adult patients, do not insert catheters into the femoral vein unless other sites are unavailable. At CMC, use a chlorhexidine-based antiseptic for skin preparation during central venous catheter insertion in patients over two months of age, unless contraindicated. Evaluate all central venous catheters routinely and remove nonessential catheters.

Educate surgery patients and their families about surgical site infection prevention. Prophylactic antimicrobial agents should be administered within 1 hour prior to incision and discontinued within 24 hours. When hair removal is necessary, use clippers or depilatories.

| Anticoagulant Therapy | Anticoagulation therapy can be used as therapeutic treatment for atrial fibrillation, DVT, PE and mechanical heart valve | KNOW: Before starting a patient on warfarin, the patient must have a baseline INR. At CMC, |
replacement. Anticoagulation medicines may cause harm due to dosing, insufficient monitoring and inconsistent patient compliance.

**Patient Safety Risk**

| Patients being treated for emotional or behavioral disorders should be assessed for risk of suicide and the immediate safety needs should be addressed. | Suicide prevention information such as a crisis hotline should be provided to the patient and their family. |

**Universal Protocol**

| Universal Protocol includes Pre-Procedure Verification, Surgical Site Marking & Time-Out for preventing wrong site, wrong procedure and wrong person surgery/invasive procedures. | Pre-Op Verification Process Should Occur to Ensure Correct Person, Correct Procedure, and Correct Site: |
| | Note: Universal Protocol does not just include procedures in the OR - Invasive procedures in non-OR settings are included |
| | • At the time the surgery/procedure is scheduled |
| | • At the time of admission or entry into the facility |
| | • Anytime responsibility for care of the patient is transferred to another caregiver |

warfarin is held when the INR is greater than 3.5.

Patient/family education should be done when the patient is started on warfarin AND at discharge if they are to continue it at home. Education should be documented and should include the importance of follow-up monitoring, compliance, drug-food interactions and the potential for adverse drug reactions and interactions.
under Universal Protocol. Universal Protocol includes any invasive procedure that exposes patients to more than minimal risk, including procedures performed in Special Procedures, Endo, Cath Lab, ER, L&D, bedside procedures, etc.

| • With the patient involved, awake and aware, if possible |
| • Before the patient leaves the pre-op area or enters the surgical/procedure room |

Site Marking  
Marking the Site:
- Mark at or near the incision site. DO NOT mark any non-operative sites
- The mark must be visible after the patient is prepped and draped
- The mark must be made using a sufficiently permanent marker to remain visible after completion of the skin prep
- See hospitalwide policy & procedure: “Universal Surgical Protocol” for cases requiring marking
- The person performing the procedure should do the site marking
- Marking must take place with the patient involved, awake and aware, if possible
- Final verification of the site mark must take place during the “time
<table>
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<tr>
<th>Time-Out</th>
<th>There must be a “Time Out” immediately before starting the procedure:</th>
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<td></td>
<td>• Must be conducted in the location where the procedure will be done</td>
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<td>• Must involve the entire operative team</td>
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<tr>
<td></td>
<td>• Must involve active communication</td>
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<tr>
<td></td>
<td>• Must be documented to include the following:</td>
</tr>
<tr>
<td></td>
<td>➢ Correct patient identity</td>
</tr>
<tr>
<td></td>
<td>➢ Correct side and site</td>
</tr>
<tr>
<td></td>
<td>➢ Agreement on the procedure to be done</td>
</tr>
<tr>
<td></td>
<td>➢ Correct patient position</td>
</tr>
<tr>
<td></td>
<td>➢ Availability of correct implants &amp; any special equipment or special requirements</td>
</tr>
<tr>
<td></td>
<td>• Any discrepancies in staff responses during the “time out” must be reconciled – Any team member should stop the process if the final verification is not clear</td>
</tr>
</tbody>
</table>
or consistent. Documentation of actions to correct a discrepancy must be recorded. Surgery/procedure cannot begin until all is in agreement.

**Non-OR Settings**
- Site marking must be done for any procedure that involves laterality, multiple structures or levels, even if the procedure takes place outside the OR.
- Cases in which the individual doing the procedure is in continuous attendance from the time of decision and consent to the conduct of the procedure may be exempted from the site marking requirement. However, the requirement for a “time out” final verification still applies.
Environment of Care/Hospital Safety Module Quiz

Coliseum Medical Centers
(Student/Faculty)

NAME __________________________________DATE___________________________

SCHOOL ________________________________FACULTY________________________

1) Match the following:

______ CODE BLUE                      A. Decon team report to decon area
______ CODE RED                       B. Emergency Situation/Accident
______ CODE TRIAGE                    C. Hazardous Material Spill
______ CODE SILVER                    D. Patient in Septic Shock
______ CODE E                        E. Cardiac/Respiratory Arrest
______ CODE PINK                     F. Mass Casualty Disaster
______ CODE ORANGE                   G. Patient With Signs of Stroke
______ RAPID RESPONSE               H. Security/Combative Situation/Person
______ CODE B                        I. Hostage Situation/Weapon
______ CODE GREY                     J. Bomb Threat
______ CODE GREEN                   K. Early and Rapid Intervention Needed
______ CODE S                       L. Infant Abduction
______ SEPSIS ALERT               M. Fire

2) To report an emergency code, dial ext. __________.

3) When using a fire extinguisher, the PASS system stands for:

   P ______________________
   A ______________________
   S ______________________
   S ______________________
4) The cornerstone of the hospital fire program is RACE which stands for:
R ______________________
A ______________________
C ______________________
E ______________________

5) TRUE or FALSE:
_______ Material Safety Data Sheets, commonly referred to as MSDS, provide detailed information on a chemical and its hazards.

_______ Disposable needles/syringes are to be immediately placed in the disposal box after being recapped, bent, clipped, or removed from the syringe.

_______ The definition of an occurrence is an unusual event which is unexpected, unintended, undesirable and departs from the standard of conduct or practice.

_______ Staff/students are not permitted to smoke anywhere on campus.

_______ Attention to patient safety is consistent with our mission and values statement and to our commitment to putting patients first.

_______ The patient has the right to refuse treatment to the extent permitted by law.

_______ Handwashing remains the single most effective method known to reduce the risk of transmission of infectious agents.

_______ It is permissible to wear artificial nails as long as they are less than ¼ inch from the tips of the fingertips and kept well manicured.

6) Isolation categories are:
___________________
___________________
___________________
7) Circle the number that shows the appropriate order for proper lifting:
   a. Bend Knees
   b. Bring objects close to the body
   c. Keep legs shoulder width apart
   d. Lift with the legs

   1. a,c,b,d
   2. c,a,b,d
   3. d,a,b,c
   4. b,a,c,d

8) If you found a back-pack lying in a corner of the back hallway on first floor you would:
   a. Pick it up and take it to the nearest nurse station
   b. Pick it up and take it to the switchboard
   c. Walk by it and assume that someone will eventually come after it
   d. Call security immediately and report a suspicious package

9) It is 0300 and someone arrives on the nursing unit with a package they want you to take. You would:
   a. Take the package, it's 0300 so who in their right mind would be out causing trouble
   b. Call your co-worker to accept the package since you don't have a “tip” on you
   c. Call Security immediately to report this incident
   d. Send them off to an empty room to wait until you have time to investigate their credentials.

10) A patient/visitor Occurrence Report form is important because:
    a. It records the events when they happen
    b. It identifies areas for improvement
    c. It ensures that follow-up action is taken when necessary
    d. All of the above

Rev. 4/06; 9/11, 08/12, 01/13, 01/14
ENVIRONMENT OF CARE/HOSPITAL SAFETY MODULE QUIZ

ANSWER SHEET- Give completed form to Faculty Instructor

Coliseum Medical Centers (Student/Faculty)

1) ________ 6) __________________
   ________
   ________
   ________
   7) ______
   ________
   ________
   8) ______
   ________
   ________
   9) ______
   ________
   ________
   10) ________

2) ______________________

3) ______________________
   ______________________
   ______________________
   ______________________

4) ______________________
   ______________________
   ______________________
   ______________________

5) ______
   ______
   ______
   ______
   ______
   ______
   ______

Date_______________________

Name_______________________

School_______________________

Faculty_______________________
HIPAA/CONFIDENTIALITY QUIZ

Coliseum Medical Centers
(Student/Faculty)

NAME ________________________________ DATE ____________________________

SCHOOL ________________________________ FACULTY __________________________

1. HIPAA is mandated by:
   a. State Law
   b. JCAHO
   c. Federal Law
   d. CMS (Center for Medicare and Medicaid Services)

2. The following are responsible for protecting patient information:
   a. CEO, CFO, ECO
   b. Physicians
   c. Hospital Employees
   d. All of the above

3. It is appropriate to share information with the following without patient authorization:
   a. Former physician of the patient’s who is concerned about the patient
   b. Colleague who needs information about the patient to provide proper care
   c. Friend of patient
   d. Pharmaceutical salesman offering fee for list of patients' names

4. HIPAA prevents which of the following:
   a. Whiteboards at nursing units
   b. Patient sign in sheets
   c. Overhead paging of patients and family members
   d. None of the above
5. Patient’s have the right to:
   a. Access their records
   b. Amend their records
   c. Opt out of the Directory
   d. All of the above

6. The following is required for release of information from the nursing unit:
   a. Patient’s Social Security Number
   b. Passcode
   c. Patient’s Medical Record Number
   d. Full Name of Patient

7. A visitor who asks for a patient by name may receive the following except for:
   a. Patient name
   b. Patient condition in general terms
   c. Patient location
   d. Patient Diagnosis

8. Good privacy practices include:
   a. Never discussing patient information in public places
   b. Creating a “hard to guess password”
   c. Logging off of locking your terminal when away from your work station
   d. All of the above

9. When faxing information you must:
   a. Remove patient identifying information before sending
   b. Call the recipient before sending to be sure they are at the receiving fax
   c. Include a HIPAA compliant cover sheet
   d. Be sure to get a fax confirmation sheet

10. Protected Health Information:
    a. Must be disposed of in secured trash bins designated for appropriate destruction
    b. Must never be left lying around in places where visitors and patients have access to it
    c. Should not be posted where anyone can view
    d. All of the above
Confidentiality and Security Agreement

I understand that the facility or business entity (the “Company”) in which or for whom I work, volunteer or provide services, or with whom the entity (e.g., physician practice) for which I work has a relationship (contractual or otherwise) involving the exchange of health information (the “Company”), has a legal and ethical responsibility to safeguard the privacy of all patients and to protect the confidentiality of their patients’ health information. Additionally, the Company must assure the confidentiality of its human resources, payroll, fiscal, research, internal reporting, strategic planning, communications, computer systems and management information (collectively, with patient identifiable health information, “Confidential Information”).

In the course of my employment / assignment at the Company, I understand that I may come into the possession of this type of Confidential Information. I will access and use this information only when it is necessary to perform my job related duties in accordance with the Company’s Privacy and Security Policies, which are available on the Company intranet (on the Security Page) and the internet (under Ethics & Compliance). I further understand that I must sign and comply with this Agreement in order to obtain authorization for access to Confidential Information.

1. I will not disclose or discuss any Confidential Information with others, including friends or family, who do not have a need to know it.
2. I will not in any way divulge, copy, release, sell, loan, alter, or destroy any Confidential Information except as properly authorized.
3. I will not discuss Confidential Information where others can overhear the conversation. It is not acceptable to discuss Confidential Information even if the patient’s name is not used.
4. I will not make any unauthorized transmissions, inquiries, modifications, or purgings of Confidential Information.
5. I agree that my obligations under this Agreement will continue after termination of my employment, expiration of my contract, or my relationship ceases with the Company.
6. Upon termination, I will immediately return any documents or media containing Confidential Information to the Company.
7. I understand that I have no right to any ownership interest in any information accessed or created by me during my relationship with the Company.
8. I will act in the best interest of the Company and in accordance with its Code of Conduct at all times during my relationship with the Company.
9. I understand that violation of this Agreement may result in disciplinary action, up to and including termination of employment, suspension and loss of privileges, and/or termination of authorization to work within the Company, in accordance with the Company’s policies.
10. I will only access or use systems or devices I am officially authorized to access, and will not demonstrate the operation or function of systems or devices to unauthorized individuals.
11. I understand that I should have no expectation of privacy when using Company information systems. The Company may log, access, review, and otherwise utilize information stored on or passing through its systems, including e-mail, in order to manage systems and enforce security.
12. I will practice good workstation security measures such as locking up diskettes when not in use, using screen savers with activated passwords appropriately, and position screens away from public view.

13. I will practice secure electronic communications by transmitting Confidential Information only to authorized entities, in accordance with approved security standards.
14. I will:
   a. Use only my officially assigned User-ID and password (and/or token (e.g., SecurID card)).
   b. Use only approved licensed software.
   c. Use a device with virus protection software.
15. I will never:
   a. Share/disclose user-IDs, passwords or tokens.
   b. Use tools or techniques to break/exploit security measures.
   c. Connect to unauthorized networks through the systems or devices.
16. I will notify my manager, Local Security Coordinator (LSC), or appropriate Information Services person if my password has been seen, disclosed, or otherwise compromised, and will report activity that violates this agreement, privacy and security policies, or any other incident that could have any adverse impact on Confidential Information.

The following statements apply to physicians using Company systems containing patient identifiable health information (e.g. CPCS/Meditech):

17. I will only access software systems to review patient records when I have that patient’s consent to do so. By accessing a patient’s record, I am affirmatively representing to the Company at the time of each access that I have the requisite patient consent to do so, and the Company may rely on that representation in granting such access to me.
18. I will insure that only appropriate personnel in my office will access the Company software systems and Confidential Information and I will annually train such personnel on issues related to patient confidentiality and access.
19. I will accept full responsibility for the actions of my employees who may access the Company software systems and Confidential Information.

Signing this document, I acknowledge that I have read this Agreement and I agree to comply with all the terms and conditions stated above.

<table>
<thead>
<tr>
<th>Employee/Consultant/Vendor/Office Staff/Physician Signature</th>
<th>Facility Name and COID</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Business Entity Name</td>
<td>Coliseum Medical Centers</td>
<td></td>
</tr>
</tbody>
</table>

Attachment to IS.SEC.005
HIPAA/CONFIDENTIALITY MODULE
QUIZ ANSWER SHEET
Give completed form to Faculty Instructor
Coliseum Medical Centers (Nursing Student/Faculty)

1) _____
2) _____
3) _____
4) _____
5) _____
6) _____
7) _____
8) _____
9) _____
10) _____

Date_____________________
Name_____________________
School_____________________
Faculty_____________________
Faculty Hospital Orientation Checklist

It is expected that faculty will submit to the Education Department this completed form, all signed Confidentiality Statements and Attestation Forms, a student roster, and the instructor’s name/phone numbers no later than the close of the first clinical practice experience for each clinical rotation.

In signing this form, the faculty agrees that:

- The following information has been provided to the nurse manager and education department:
  - List of instructors and phone numbers
  - Schedule of students; list of names
  - Clinical rotation schedule
  - Name/phone number/fax number of person who holds copies of all information indicated on individual attestation forms:
    ______________________________________________________
    ______________________________________________________
    ______________________________________________________

- Students/Faculty have received a unit orientation for the following (as appropriate):
  - Location of fire extinguishers and fire pulls
  - Emergency codes and appropriate response
  - Documentation process
  - eMAR
  - IV/Therapy procedure/Glucometer competence
  - Other policy and procedure/equipment review as appropriate

_________________________________________ ______________________
Faculty Signature    School    Date

_________________________________________ ______________________
Unit Manager Signature   Unit    Date

\[^1\] TJC PC.03.05.01
\[^2\] HCA Best Practice
\[^3\] HCA Best Practice
\[^4\] TJC PC.03.05.05; CMS §482.13(e)(6)
\[^5\] TJC PC.03.05.05; CMS §482.13(e)(6)
Appendix A: Training Requirements
Appendix B: Alternatives to Restraint
Appendix C: Reporting Requirements
Appendix D: Reporting Forms
Appendix E: Definition